



## **Individual Health Insurance**

### **Exclusive Provider Organization (EPO) Medical and Outpatient Prescription Drug Plan**

#### **Certificate of Coverage**

#### **Underwritten by Peak Health Insurance Corporation**

##### **IMPORTANT NOTICES:**

- **Notice of Non-Discrimination:**  
**Peak Health Insurance Corporation** does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.
- **Sanctioned Countries:**  
If coverage provided under this Policy violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, We cannot pay for Eligible Health Services if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). Visit <https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx> to find out more.

## Welcome

Thank you for choosing Peak Health.

Please read this COC carefully. If you are not satisfied, return this Certificate of Coverage to us within ten (10) calendar days after you received it. Upon return, this COC will be deemed void, and any Premium will be refunded. In such event, any Health Care Services received during this ten (10) calendar day period are solely your responsibility.

This is Your Certificate of Coverage. It is one of two documents that together describe the benefits covered by Your Peak Health plan.

This Certificate of Coverage will tell You about Your Covered Benefits – what they are and how You get them. It is Your Certificate of Coverage under the Policy, and it replaces all certificates of coverage describing similar coverage that were previously sent to You. The second document is the Statement of Benefits. The Statement of Benefits tells You how We share expenses for Eligible Health Services and tells You about limits – like when Your plan covers only a certain number of visits.

Sometimes, We may send You documents that are amendments, endorsements, attachments, inserts or riders. They change or add to the documents that they're part of. When You receive these, they are considered part of Your Peak Health plan for coverage.

Where to next? Take a look at the *Table of Contents* section or try the *Let's Get Started!* section right after it. The *Let's Get Started!* section gives You a summary of how Your plan works. The more You understand, the more You can get out of Your plan.

Welcome to Your Peak Health plan.

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## Let's Get Started!

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Here are some basics. First things first – some notes on *How We Use Words*. Then We explain how Your plan works so You can get the most out of Your coverage. But for all the details – and this is very important – You need to read this entire Certificate of Coverage and the Statement of Benefits. And if You need help or more information, We tell You how to reach us.

### How We Use Words in the Certificate of Coverage and Statement of Benefits

- When We say “You” and “Your”, We mean the Covered Policyholder and any Covered Dependents;
- When We say “Us”, “We”, and “Our”, We mean Peak Health;
- Some words in this Certificate of Coverage and Statement of Benefits are capitalized. We define these capitalized terms in the *Definitions* section; and
- Sometimes We use technical medical language that is familiar to medical providers.

### What Your Plan Does – Providing Covered Benefits

Your plan provides Covered Benefits. Covered Benefits are Eligible Health Services for which Your plan has the obligation to pay.

This plan provides Covered Benefits for medical and Pharmacy services.

### How Your Plan Works – Starting and Stopping Coverage

You may renew this Policy from month to month by paying the premiums as specified below. Except as authorized by the West Virginia Offices of the Insurance Commissioner we shall neither cancel nor non-renew this Policy. Any non-renewal by us will be without prejudice to any Claim Incurred prior to the date of non-renewal.

### Premiums

#### Initial

You must pay the initial premium on or before the Effective Date of this Policy. This Policy will not be in force until we have received this premium.

### Grace Period, Cancellation for Nonpayment and Reinstatement

This Policy will automatically renew monthly as long as you pay the premiums when due. For further periods of coverage, the required premiums must be paid in advance or within a grace period of thirty-one (31) days after the due date.

For individuals who are enrolled in a Qualified Health Plan through the Health Insurance Exchange Marketplace (“Exchange”), if we do not receive the required premium from you by the end of the grace period, your coverage will be cancelled effective as of the due date for which the required premium was not received. Your billing statement from us may be used to provide you with final notice of

cancellation of your coverage. Section III contains additional information regarding grace periods and eligibility. If premiums are delinquent for a Member who receives Advance Premium Tax Credit, and at least one month's premium has been paid in full during the benefit year, coverage will be terminated after the exhaustion of a three (3) month grace period. Benefits will only be provided under this Policy for Covered Services received during the first month of the three (3) month grace period if payment of the appropriate premium amount by the Covered Person is not received prior to the end of the grace period. Failure of Peak Health to receive Advance Payment of Premium Tax Credits shall not be grounds for termination of this Policy.

For Qualified Health Plans purchased directly from Peak Health and not through the Exchange, the right to reinstatement is limited to one (1) reinstatement during any twelve (12) month period and two (2) reinstatements during the Policyholder's lifetime.

## **Member Rights and Responsibilities**

### **You have the right to:**

- Receive information about Peak Health, Our products and services, Our Network Providers, and Your rights and responsibilities.
- Be treated with respect and recognition of Your dignity and right to privacy.
- Participate with practitioners in decision-making regarding Your health care. This includes the right to be informed of Your diagnosis and treatment plan in terms that You understand and participate in decisions about Your care.
- Have a candid discussion of appropriate and/or Medically Necessary and Appropriate treatment options for Your condition(s), regardless of cost or benefit coverage.
- Voice a Complaint or file an Appeal about Peak Health or the care provided and receive a reply within a reasonable period of time.
- Make recommendations regarding the Peak Health Members' Rights and Responsibilities policies.
- Receive advance explanation of benefits (EOBs) for Covered Services from a particular Provider. EOBs will include, among other items deemed necessary by Peak Health, information regarding whether the provider is a Network or Out-of-Network Provider; a good faith estimate of the Plan Allowance, Your applicable Cost-sharing and impact on the Deductible and Out-of-Pocket accumulations; and whether any medical management requirements apply.

### **You have a responsibility to:**

- Supply to the extent possible, information that the organization needs in order to make care available to You, and that its practitioners and Providers need in order to care for you.
- Follow the plans and instructions for care that You have agreed on with your practitioners.
- Communicate openly with the Physician You choose. Ask questions and make sure You understand the explanations and instructions You are given, and participate in developing mutually agreed upon treatment goals. Develop a relationship with Your Physician based on trust and cooperation.

- Be enrolled and pay any required premiums.
- Report any suspicion of fraud, waste, and abuse using the reporting mechanisms located in this handbook.
- Show Your ID card to make sure you receive full benefits under this plan.

## **Eligible Health Services**

Physician and Hospital services are the foundation for many other services. You'll probably find the preventive care, Emergency Services and Urgent Condition coverage especially important. But the plan won't always cover the services You want. Sometimes it doesn't cover health care services Your Physician will want You to have.

So what are Eligible Health Services? They are health care services that meet these three requirements:

- They are listed in the *Eligible Health Services and Exclusions* section;
- They are not carved out in the *General Exclusions* section; and
- They are not beyond any limits in the Statement of Benefits.

## **Paying for Eligible Health Services – General Requirements**

There are several general requirements for the plan to pay any part of the expense for an Eligible Health Service. They are:

- The Eligible Health Service is Medically Necessary;
- You receive the Eligible Health Service from an In-Network Provider when required.
- You or Your Provider Precertifies the Eligible Health Service when required.

You will find details on Medical Necessity and Precertification requirements in the *Medical Necessity and Precertification Requirements* section.

## **Paying for Eligible Health Services– Sharing the Expense**

Generally, Your plan and You will share the expense of Your Eligible Health Services when You meet the general requirements for paying.

But sometimes Your plan will pay the entire expense and sometimes You will. For more information see the *What the Plan Pays and What You Pay* section, and see the Statement of Benefits.

## **Disagreements**

The plan explains the process We will use to resolve any potential disagreements relating to this Policy. If We are unable to reach an agreement, an independent group of experts called an “external review organization” or ERO for short, will make the final decision for Us.

For more information see the *Claim Decisions and Appeals Procedures* section.

## **Types of Coverage -**

### **In-Network Coverage**

Your in-network coverage helps you:

- Get and pay for a lot of – but not all – health care services; and
- Pay less cost share when You use a In-Network Provider.

Generally Your in-network coverage will pay only when You get care from an In-Network Provider.

### **Our Network of Providers**

Peak Health's network of Physicians, Hospitals and other health care Providers is there to give You the care that You need. You can find In-Network Providers and see important information about them most easily on Our online Provider Directory. Just log in to Your Peak Health website at [peakhealth.org](http://peakhealth.org).

If You can't find an In-Network Provider for a service or supply that You need, call Member Services at the toll-free number on Your ID card in the *How to Contact Us for Help* section. We will help You find an In-Network Provider. If We can't find one, We will give You a pre-approval to get the service or supply from an Out-of-Network Provider. When You get a pre-approval for an Out-of-Network Provider, Covered Benefits are paid at the in-network coverage level of benefits.

### **Out-of-Network Coverage**

In addition to Your in-network coverage, You also have coverage when:

- You receive Emergency Health Care Services
- You receive Urgent Care Services while you are temporarily outside the Service Area
- There is a specific situation involving continuity of your health care, as explained below in the *Who Provides the Care* section
- You receive Health Care Services from a Non-Network Provider (such as a radiologist, anesthesiologist, pathologist, Emergency Room Physician or consulting Physician) while you are in a Hospital or other Facility that is a Network Provider; or
- The Health Care Services you need are Covered Services under the Plan and not available from a Network Provider or Facility based on West Virginia requirements. In this case, you, your PCP, or Non-Network Provider must obtain our Precertification.

Some services from non-network providers may require Precertification. These benefits will have the same Copay, Coinsurance, and Deductible requirements as those Health Care Services would have had if received from a Network Provider.

### **Surprise Bill**

There may be times when You unknowingly receive services or don't consent to receive services from an Out-of-Network Provider, even when You try to stay in the network for Your Eligible Health Services. You may get a bill at the out-of-network rate that You didn't expect. This is called a surprise bill. Exception: You will not receive a bill for emergency ground ambulance services provided by an

out of network provider.

An Out-of-Network Provider cannot attempt to balance bill or collect costs from You that exceed Your in-network cost-sharing requirements, such as Deductibles, Copayments and Coinsurance for the following services:

- Emergency Services provided by an Out-of-Network Provider and ancillary services initiated from Your Emergency Service;
- Non-emergency services provided by an Out-of-Network Provider at an in-network facility, except when the Out-of-Network Provider has given You the following:
  - The out-of-network notice for Your signature;
  - The estimated charges for the items and services; and
  - Notice that the Provider is an Out-of-Network Provider; and
- Out-of-network air Ambulance services.

The Out-of-Network Provider must get Your consent to be treated and balance billed by them.

Ancillary services mean any professional services including:

- Anesthesiology;
- Hospitalist services;
- Items and services related to emergency medicine;
- Laboratory services;
- Neonatology;
- Pathology;
- Radiology; and
- Services provided by an Out-of-Network Provider because there was no In-Network Provider available to perform the service.

A facility in this instance means an institution providing health care related services, or a health care setting. This includes the following:

- Hospitals and other licensed inpatient centers;
- Ambulatory surgical or treatment centers;
- Skilled Nursing Facilities;
- Residential Treatment Facilities;
- Diagnostic, laboratory, and imaging centers;
- Rehabilitation facilities; and
- Other therapeutic health settings.

A surprise bill claim is paid based on the median contracted rate for all plans offered by Us in the same insurance market for the same or similar item or service that is all of the following:

- Provided by a Provider in the same or similar specialty or facility of the same or similar facility type; and
- Provided in the geographic region in which the item or service is furnished.

The median contracted rate is subject to additional adjustments as specified in federal regulations.

Any cost share paid with respect to the items and services will apply toward Your in-network Deductible and Maximum Out-of-Pocket Limit, if You have one.

It is not a surprise bill when You knowingly choose to go out-of-network and have signed a consent notice for these services. In this case, You are responsible for all non-covered charges.

If You receive a surprise bill or have any questions about what a surprise bill is, please contact us.

## How to Contact Us for Help

We are here to answer Your questions. You can contact Us by:

- Calling Our Member Services at the toll-free number on Your ID card 1-833-569-7325;
- Writing Us at Peak Health Insurance Corporation, 1085 Van Voorhis Rd, Suite 300  
Morgantown, WV 26505; or
- Visiting [peakhealth.org](https://peakhealth.org) to register and access Your Peak Health account.

Our online tools will make it easier for You to make informed decisions about Your health care, view claims, research care and treatment options, and access information on health and wellness. You may also contact the West Virginia Offices of the Insurance Commissioner at:

### WV Offices of the Insurance Commissioner

L&H Department, PO Box 50540, Charleston, West Virginia 25305-0540  
304-720-8584

OICConsumerServicesLH@wv.gov

<https://www.wvinsurance.gov>

## Your Digital ID card

We issued to You a digital ID card which You can view or print by going to the website at [peakhealth.org](https://peakhealth.org) or [Mypeak.peakhealth.org](https://mypeak.peakhealth.org). When visiting Physicians, Hospitals, and other Providers, You don't need to show them an ID card. Just provide Your name, date of birth and either Your digital ID card or member ID. The Provider office can use that information to verify Your eligibility and benefits with Member Service.

Remember, only You and Your Covered Dependents can use Your digital ID card. If You misuse Your card by allowing someone else to use it, that is fraud and We may end Your coverage. See the *Honest Mistakes and Intentional Deception* section for details.

If You don't have internet access, call Member Services at the toll-free number in the *Contact Us* section. You can also access Your ID card when you're on the go. To learn more, visit Us at [Mypeak.peakhealth.org](https://mypeak.peakhealth.org).

## **Your ID card**

We mailed an ID card to You. Your ID card tells Physicians, Hospitals, and other Providers that You are covered under this Peak Health plan. Show Your ID card each time You get health care services from a Provider to help them bill Us correctly and help Us better process their claims.

Remember, only You and Your Covered Dependents can use Your ID card. If You misuse Your card by allowing someone else to use it, that is fraud and We may end Your coverage. See the *Honest Mistakes and Intentional Deception* section for details.

If You have not received Your ID card prior to needing Eligible Health Services, or if you've lost it, You can print a temporary ID card. Log in to Your Peak Health account at [Mypeak.peakhealth.org](https://mypeak.peakhealth.org) or call Member Services at the toll-free number 1-833-569-7325.

## Who the Plan Covers

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If you are seeking Benefits under this Plan through the Marketplace, the Marketplace is solely responsible for:

- Determining whether you are eligible for Benefits under the Plan;
- The application and enrollment processes; and
- Determining your subsidy level.

Information regarding enrollment options is available from the Marketplace at [healthcare.gov](https://healthcare.gov). Additional information on how to contact the Marketplace is available at [peakhealth.org/aca](https://peakhealth.org/aca).

## Eligibility Requirements

To be eligible for coverage under the Plan through the Marketplace, you and your Dependents must meet all of the Marketplace's eligibility requirements. Eligibility is determined by the Marketplace and not by Peak Health. Generally, you will qualify if you:

- Are a citizen of the United States or a lawfully present immigrant;
- Are not incarcerated, other than incarceration pending the disposition of charges; and
- Are a resident of the State of West Virginia and reside within the Plan's Service Area.

If you are seeking coverage outside of the Marketplace, you and your Dependents must meet all of the Plan's eligibility requirements. Generally, you will qualify if you are a resident of the State of West Virginia and reside within the Plan's Service Area.

Peak Health or the Marketplace may ask for verification that you are eligible for coverage under the Plan. You must show proof that you meet and continue to meet the conditions above. Coverage under this Plan is available to you no matter what your health condition is.

Dependents who are eligible to participate in the Plan include:

- Your legally recognized spouse.
- Your domestic partner. To qualify as a domestic partner, you must:
  - Have a serious, committed relationship with the Covered Person;
  - Be financially interdependent;
  - Not be related to the Covered Person in any way that would prohibit legal marriage by state law;
  - Not be legally married to anyone else;
  - Not be a domestic partner of anyone else; and
  - Not be in a relationship that violates state or local laws.
- Your natural blood related child, stepchild, legally adopted child, a child for who you have legal guardianship, including a child placed in your foster care, or your child who is entitled to coverage under this Plan because of a medical child support order whose age is less than the limiting age. A Dependent child is eligible for coverage until the end of the Benefit Year in which the child reaches the limiting age of 26.
- Your Dependent child over the age of 26 if that child is incapable of self-sustaining

employment by reason of developmental or intellectual disabilities or physical handicap and is primarily dependent upon you for support and maintenance.

## **Medicare Eligibility**

You are not eligible for health coverage under this Policy if You are entitled to Medicare benefits under Part A (receiving free Part A) or enrolled in Part B at the time of enrollment in this plan.

## **Joining this Plan**

You can enroll Yourself and Your dependents

- During the open enrollment period; or
- At other special times during the year (see the *Special Times You and Your Dependents Can Join the Plan* section below)

## **Eligible Dependents**

An Eligible Dependent is a U.S. citizen, national or other individual lawfully present in the United States:

- not entitled for benefits under Medicare Part A or enrolled in Medicare Part B, Medicaid or CHIP;
- not incarcerated (other than incarceration pending the disposition of charges);
- be an Indian, as defined for purposes of the Affordable Care Act; and
- who has been identified by the Policyholder through the appropriate enrollment process or on an Application form accepted by the Plan as:
  - a. The Policyholder's spouse under a legally valid existing marriage;
  - b. The Policyholder's Domestic Partner for the duration of the Domestic Partnership. In addition, the child(ren) of the Domestic Partner shall be considered, for eligibility purposes, as if they were the child(ren) of the Policyholder as long as the Domestic Partnership exists; or
  - c. The Policyholder's child, including a newborn child, step-child, child legally placed for adoption, child awarded coverage pursuant to an order of court, and legally adopted child of the Policyholder or Policyholder's spouse. The limiting age for a covered child is twenty-six (26), unless the period of eligibility for such Dependent is otherwise extended pursuant to applicable state or federal law. Covered children who turn twenty-six (26) during a Benefit Period will be terminated from coverage at the end of the Benefit Period.

Eligibility will be continued past the Benefit Period during which a Dependent child turns age twenty-six (26) for the Policyholder's unmarried child who, as medically certified by a Physician, is incapable of self-support due to intellectual disability or physical disability that started before age twenty-six (26). If a Dependent child meets this criteria, the Member should contact the Plan at the telephone number on the Member ID Card. The Plan may require proof of such Dependent's disability from time to time.

## **Changes in Eligibility**

For Peak Health to administer consistent coverage for you and your Dependents, you must inform us immediately of any changes in eligibility (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage. Changes in coverage regarding Deductibles can only be made at the time of renewal.

Each new Dependent must be added by Application to your Policy within 60 days of the event, regardless of whether you have individual or family coverage in effect.

If you applied for individual coverage, you can change to family coverage if you marry or acquire a child or children. You must notify us of the change within 60 days of the event.

NOTE: To notify us of changes, you must submit all necessary forms to us within 60 days of the event to add a newly acquired dependent.

Family coverage should be changed to individual coverage when only the Policyholder is an eligible individual. In addition, you must notify us when a Covered Person under your Policy becomes eligible for Medicare.

## **Annual Enrollment**

If you are covered by a Qualified Health Plan (QHP) offered through an Health Insurance Marketplace Exchange (“Exchange”), you may be required to enroll annually. You will receive a notification prior to the Annual Open Enrollment Period.

## **Special Enrollment**

You may be permitted a Special Enrollment Period of 60 days through an Exchange from the date of occurrence of any of the following triggering events:

- A Qualified Individual or Dependent (including a spouse/Domestic Partner) of an enrollee loses other minimum essential coverage – including, for example, a loss of coverage due to divorce or legal separation; a Dependent child who reaches the Dependent age limitation; termination of employment or a reduction in hours; relocation outside a QHP’s Service Area; loss of Medicaid or CHIP coverage; or decertification of a QHP outside the Annual Enrollment Period (if the individual does not select a new QHP before the Effective Date of the decertification);
- Qualified Individuals who lose minimum essential coverage are eligible for a Special Enrollment Period even if they are offered COBRA continuation coverage, provided that they do not actually enroll in such COBRA coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption, or placement for adoption;
- An individual who was not previously a U.S. citizen or national, or lawfully present in the U.S., gains such status;
- A Qualified Individual’s previous enrollment or non-enrollment in a QHP was unintentional, inadvertent, or erroneous, and resulted from an error, misrepresentation, or inaction of an officer,

employee, or agent of the Exchange or HHS;

- An individual is determined to be newly eligible or ineligible for Advance Payments of The Premium Tax Credit, or has a change in eligibility for cost-sharing reductions, regardless of whether or not they are already enrolled in a QHP;
- The Exchange must provide a Special Enrollment Period to an individual whose existing coverage under an eligible employer-sponsored plan will no longer be “affordable” or provide “minimum value” for the employer’s upcoming plan year;
- A Qualified Individual or enrollee gains access to new QHPs offered through the Exchange, as a result of a permanent move;
- An Indian may enroll in a QHP, or change from one QHP to another, once per month; or
- An individual meets “other exceptional circumstances” as the Exchange or HHS may provide, including those that would impede his or her ability to enroll on a timely basis, through no fault of his or her own (e.g., a natural disaster).

## **Guaranteed Renewability**

For individuals who are enrolled in a QHP through an Exchange, your coverage will renew or continue in force except in situations involving nonpayment of premiums, fraud, termination of the plan, enrollee’s movement outside the Service Area or discontinuance of a product or all coverage.

## **Medical Necessity and Precertification Requirements**

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The starting point for Covered Benefits under Your plan is whether the services and supplies are Eligible Health Services. See the *Eligible Health Services and Exclusions* and *General Exclusions* sections plus the Statement of Benefits.

Your plan pays for its share of the expense for Eligible Health Services only if the general requirements are met. They are:

- The Eligible Health Service is Medically Necessary;
- You or Your Provider Precertifies the Eligible Health Service, when required.

### **Medically Necessary; Medical Necessity**

As We said in the *Let's Get Started!* section, Medical Necessity is a requirement for You to receive a Covered Benefit under this plan.

The Medical Necessity requirements are stated in the *Definitions* section, where We define "Medically Necessary, Medical Necessity". That is where We also explain what Our medical directors or their Physician designees consider when determining if an Eligible Health Service is Medically Necessary.

Our clinical policy bulletins explain Our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under Our plans. You can find the bulletins and other information at [peakhealth.org](http://peakhealth.org).

### **Precertification**

You need Precertification from Us for some Eligible Health Services. You need to submit precertification forms, including any related communication, via the Peak Health Online Portal available at [peakhealth.org](http://peakhealth.org). Peak shall accept one Precertification per episode of care.

### **Precertification for Medical Services and Supplies**

#### ***In-Network Care***

Your in-network Physician is responsible for obtaining any necessary Precertification before You get the care. If Your in-network Physician doesn't get a required Precertification, We won't pay the Provider who gives You the care. You won't have to pay either if Your in-network Physician fails to ask Us for Precertification. If Your in-network Physician requests Precertification and We refuse it, You can still get the care but the plan won't pay for it. You will find details on requirements in the *What the Plan Pays and What You Pay* section and *Important Exceptions –When You Pay All* provision.

### **Precertification Information**

After We have received a Precertification request, We will communicate Our claim decisions in accordance with the timeframes provided in the *Types of Claims and Communicating Our Claim Decisions* provision of this Certificate.

### Notification for Certain Medical Conditions

You must notify Us for certain medical conditions within the timeframe specified below. No penalty will apply if You fail to notify us. To notify us, call the Member Services toll-free number on Your ID card or submit notification through the website on your ID card in the **How to Contact Us for Help** section.

|                                     |                                                                                                                                                                         |
|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| For an Emergency Medical Condition: | You, Your Physician or the facility must notify us within 24 hours or as soon as reasonably possible after receiving emergency outpatient care, treatment or procedure. |
| For prenatal care:                  | As soon as possible after Your Physician confirms pregnancy so that We can enroll You in Our care management program.                                                   |

### Written Notification of Precertification decisions

We will provide a written or electronic notification to You and Your Physician of the Precertification decision, where required by state law and within the timeframe specified by state law. If Your Precertified services are approved, the approval is valid for up to one year. and will carry over to and from other plans and carriers.

### Inpatient and Outpatient Precertification

When You have an inpatient admission to a facility, We will notify you, Your physician and the facility about Your Precertified length of stay. If Your physician recommends that Your stay be extended, additional days will need to be Precertified. You, Your physician, or the facility will need to submit a request through the website on your ID card as soon as reasonably possible, but no later than the final authorized day. We will review and process the request for an extended stay. You and Your physician will receive a notification of an approval or denial. Providers receive timely precertification decisions through notification letters, secure messages in the Peak Provider Portal, or direct telephone outreach. Members are informed of precertification decisions through notification letters or secure messaging within the Peak MyChart member portal.

When You have an outpatient service or supply that requires precertification, We will notify you, Your physician and the facility about Your Precertified outpatient service or supply. If Your physician recommends that Your outpatient service or supply benefits be extended, the additional outpatient benefits will need to be Precertified. You, Your physician, or the facility will need to submit a request through the website on your ID card as soon as reasonably possible, but no later than the final day of the authorized outpatient service or supply. We will review and process the request for the extended outpatient benefits. You and Your physician will receive a notification of an approval or denial.

If Precertification determines that the stay or outpatient services and supplies are not Covered Benefits, the notification will explain why and how You can appeal Our decision. You or Your Provider may request a review of the Precertification decision. See the *When You Disagree - Claim Decisions and Appeals Procedures* section.

As part of the Precertification process, We may ask You to get a second or third opinion

through an independent medical exam. If We require You to do so, the exam(s) will be covered at 100% and will not be subject to the Policy Year Deductible.

### **What if You Don't Obtain the Required Precertification?**

If You don't obtain the required Precertification:

- Your benefits may be reduced, or the plan may not pay any benefits. See the *Precertification Covered Benefit Penalty provision* in the Statement of Benefits;
- You will be responsible for the unpaid balance of the bills; and
- Any additional out-of-pocket expenses incurred will not count toward Your out-of-network Policy Year Deductibles or Maximum Out-of-Pocket Limits.

### **What Types of Services and Supplies Require Precertification?**

Precertification is required for the following types of services and supplies:

| <b>Inpatient Services and Supplies</b>                                             | <b>Outpatient Services and Supplies</b>                                                                                                                               |
|------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Gene-based, cellular and other innovative therapies (GCIT)                         | Applied behavior analysis                                                                                                                                             |
| Obesity (bariatric) Surgery                                                        | Certain Prescription Drugs and devices*                                                                                                                               |
| Stays in a Hospital                                                                | Complex imaging                                                                                                                                                       |
| Stays in a Rehabilitation Facility                                                 | Comprehensive Infertility services                                                                                                                                    |
| Stays in a Residential Treatment Facility for treatment of Mental Health Disorders | Cosmetic and reconstructive Surgery                                                                                                                                   |
| Stays in a Skilled Nursing Facility                                                | Gene-based, cellular and other innovative therapies (GCIT)                                                                                                            |
|                                                                                    | Home health care                                                                                                                                                      |
|                                                                                    | Certain Injectable medications such as, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)* |
|                                                                                    | Kidney dialysis                                                                                                                                                       |
|                                                                                    | Knee Surgery                                                                                                                                                          |
|                                                                                    | Non-emergency transportation by airplane                                                                                                                              |
|                                                                                    | Outpatient back Surgery not performed in a Physician's office                                                                                                         |
|                                                                                    | Partial Hospitalization Treatment – Mental Health Disorder                                                                                                            |
|                                                                                    | Private duty nursing services                                                                                                                                         |
|                                                                                    | Sleep studies                                                                                                                                                         |
|                                                                                    | Transcranial magnetic stimulation (TMS)                                                                                                                               |
|                                                                                    | Wrist Surgery                                                                                                                                                         |

\*For a current listing of the Prescription Drugs and medical Injectable Drugs that require Precertification, please contact Member Services by calling the toll-free number on Your ID

card in the How to Contact Us for Help section or by logging in to the Peak Health website at [peakhealth.org](http://peakhealth.org).

Sometimes You or Your Provider may want Us to review a service that doesn't require Precertification before You get care. This is called a predetermination, and it is different from Precertification.

Predetermination means that You or Your Provider requests the pre-service clinical review of a service that does not require Precertification.

### **Precertification for Prescription Drugs and Devices**

Certain Prescription Drugs and devices are covered under the medical plan when they are given to You by Your Physician or health care facility and not obtained at a Pharmacy. The following Precertification information applies to these Prescription Drugs and devices.

For certain Prescription Drugs and devices, Your Prescriber or Your pharmacist needs to get approval from Us before We will agree to cover the Prescription Drug or device for You. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain Prescription Drugs and devices and makes sure there is a Medically Necessary need for the Prescription Drug or device. For the most up-to-date information, call Member Services at the toll-free number on Your ID card in the *How to Contact Us for Help* section or log in to Your Peak Health website at <https://memberportal.navitus.com/>

If You do not Precertify a Prescription Drug or device, a penalty will apply. See the Statement of Benefits. Contact Your Prescriber or pharmacist if a Prescription Drug or device requires Precertification.

### **Step Therapy**

There is another type of Precertification for Prescription Drugs, and that is Step Therapy. Step Therapy is a type of Precertification where We require You to first try certain drugs to treat Your medical condition before We will cover another drug for that condition.

You can obtain the most up-to-date information about Step Therapy Prescription Drugs by calling Member Services at the toll-free number on Your ID card in the *How to Contact Us for Help* section or by logging in to Your Peak Health website at [memberportal.navitus.com/](http://memberportal.navitus.com/) Your Physician can find additional details about the Step Therapy Prescription Drugs in Our clinical policy bulletins.

### **Requesting a Medical Exception for Prescription Drugs**

Sometimes You or Your Provider may ask for a medical exception for Prescription Drugs that are not covered or for which coverage was denied. You, someone who represents You or Your Provider can contact us. You will need to provide Us with the required clinical documentation. Any exception granted is based upon an individual and is a case by case decision that will not apply to other Covered Persons.

For directions on how You can submit a request for a review:

- Contact Member Services at the toll-free number on Your ID card 1-833-569-7325;
- Go online at <https://memberportal.navitus.com> or
- Submit the request in writing to Peak Health Insurance Corporation, 1085 Van Voorhis Rd, Suite 300, Morgantown, WV 26505.

You, someone who represents You or Your Provider may seek a quicker medical exception when the situation is urgent. It's an urgent situation when You have a health condition that may seriously affect your life, health, or ability to get back maximum function. It can also be when You are going through a current course of treatment using a non-covered drug.

## **Eligible Health Services and Exclusions**

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The information in this section is the first step to understanding Your plan's Eligible Health Services. These services are:

- Described in this section;
- Not listed as exclusions in this section or the *General Exclusions* section; and
- Not beyond any limitations in the Statement of Benefits.

Your plan covers many kinds of health care services and supplies, such as Physician care and Hospital Stays. But sometimes those services are not covered at all or are covered only up to a limit.

For example:

- Physician care generally is covered but Physician care for Cosmetic Surgery is never covered. This is an exclusion.
- Home health care is generally covered but it is a Covered Benefit only up to a set number of visits a year. This is a limitation.

We explain Eligible Health Services and exclusions in this section. You can find out about general exclusions in the *General Exclusions* section and about limitations in the Statement of Benefits.

We've grouped the health care services below to make it easier for You to find what you're looking for.

**Important note:**

Sex-specific Eligible Health Services are covered when medically appropriate, regardless of identified gender.

## 1. Preventive Care and Wellness Benefit

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This section describes the Eligible Health Services and supplies available under Your plan when You are well.

### **Important notes:**

1. You will see references to the following recommendations and guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- United States Preventive Services Task Force;
- Health Resources and Services Administration; and
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

These recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the Calendar Year, one year after the updated recommendation or guideline is issued.

2. Diagnostic testing for the treatment or diagnosis of a medical condition will not be covered under the Preventive Care and Wellness benefit. For those types of tests and treatment, You will pay the cost sharing specific to Eligible Health Services for diagnostic testing and treatment.
3. Gender-specific preventive care and wellness benefits include Eligible Health Services described below regardless of the sex you were assigned at birth, Your gender identity, or Your recorded gender.
4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact Your Physician or contact Member Services by logging in to Your Peak Health website at [peakhealth.org](https://www.peakhealth.org) or by calling the toll-free number on Your ID card in the *How to Contact Us for Help* section. This information can also be found at the <https://www.healthcare.gov> website.

## **Routine Physical Exams**

Eligible Health Services include office visits to Your Physician or other Health Professional for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a Physician for a reason other than to diagnose or treat a suspected or identified Illness or Injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents;
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
  - Screening for gestational diabetes for women; and
- High-risk Human Papillomavirus (HPV) DNA testing for women age 30–65 and limited to once every 5 years or once every 3 years for self-collected samples. Note patient obtained samples for cervical cancer screen will have \$0 cost share. Radiological services, lab and other tests given in connection with the exam; or
- For newborns, an initial Hospital checkup, including any required testing for diseases specified by the State Public Health Commissioner.

## **Preventive Care Immunizations**

Eligible Health Services include immunizations provided by Your Physician or other Health Professional for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment is not covered under this benefit.

## **Well Woman Preventive Visits**

Eligible Health Services include Your routine:

- Well woman preventive exam office visit to Your Physician, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes Pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified Illness or Injury;
- Preventive care breast cancer (BRCA) gene blood testing by a Physician and lab;

- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment;
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy; and
- Screening for urinary incontinence.

## **Preventive Screening and Counseling Services**

Eligible Health Services include screening and counseling by Your Health Professional for some conditions. These are obesity counseling, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services You get in an individual or group setting.

- **Obesity and/or Healthy Diet Counseling**

Eligible Health Services include the following screening and counseling services to aid in weight reduction due to obesity:

- Preventive counseling visits and/or risk factor reduction intervention;
- Nutritional counseling; and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

- **Misuse of Alcohol and/or Drugs**

Eligible Health Services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:

- Preventive counseling visits;
- Risk factor reduction intervention; and
- A structured assessment.

- **Use of Tobacco Products**

Eligible Health Services include the following screening and counseling services to help You to stop the use of tobacco products:

- Preventive counseling visits;
- Treatment visits; and
- Class visits.

Tobacco products means any substance containing tobacco or nicotine, such as:

- Cigarettes;
- Cigars;
- Smoking tobacco;
- Snuff;
- Smokeless tobacco; and

- Candy-like products that contain tobacco.
- **Sexually Transmitted Infection Counseling**  
Eligible Health Services include the counseling services to help You prevent or reduce sexually transmitted infections.
- **Genetic Risk Counseling for Breast and Ovarian Cancer**  
Eligible Health Services include counseling and evaluation services to help You assess whether or not You are at increased risk for breast and ovarian cancer.

## **Routine Cancer Screenings**

Eligible Health Services include the following routine cancer screenings:

- Mammograms;
- Prostate specific antigen (PSA) tests;
- Digital rectal exams;
- Fecal occult blood tests;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE);
- Colonoscopies (includes:
  - Bowel preparation medications;
  - Anesthesia;
  - Removal of polyps performed during a screening procedure; and
  - Pathology exam on any removed polyps); and
- Lung cancer screenings.

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

## **Prenatal Care**

Eligible Health Services include Your routine prenatal physical exams as *Preventive Care and Wellness*, which is the initial and subsequent history and physical exam such as:

- Maternal weight;
- Blood pressure;
- Fetal heart rate check;
- Fundal height; and

- Preeclampsia screening.

You can get this care at Your Physician's, OB's, GYN's, or OB/GYN's office (including Telemedicine consultations).

**Important note:**

You should review the benefit under *Eligible Health Services and Exclusions – Maternity Care and Well Newborn Nursery Care* section of this Certificate of Coverage for more information on coverage for pregnancy expenses under this plan.

## **Comprehensive Lactation Support and Counseling Services**

Eligible Health Services include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast-feeding. Your plan will cover this when You get it in an individual or group setting. Your plan will cover this counseling only when You get it from a certified lactation support Provider.

## **Breastfeeding Durable Medical Equipment**

Eligible Health Services include renting or buying Durable Medical Equipment You need to pump and store breast milk as follows:

### **Breast Pump**

Eligible Health Services include:

- Renting a Hospital grade electric pump while Your newborn child is confined in a Hospital
- The buying of:
  - An electric breast pump (non-Hospital grade, cost is covered by Your plan once per pregnancy) or
  - A manual breast pump (cost is covered by Your plan once per pregnancy).

### **Breast Pump Supplies and Accessories**

Eligible Health Services include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, including the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment You purchase or rent for personal convenience or mobility.

## **Family Planning Services – Female Contraceptives**

Eligible Health Services include family planning services such as:

### **Counseling Services**

Eligible Health Services include counseling services provided by a Provider on contraceptive

methods. These will be covered when You get them in either a group or individual setting.

### **Contraceptives**

Eligible Health Services include contraceptive Prescription Drugs and devices (including any related services or supplies) when they are provided by, administered, or removed by a Provider.

### **Voluntary Sterilization**

Eligible Health Services include charges billed separately by the Provider for voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

#### **Important note:**

See the following benefit provisions for more information:

- *Family Planning Services – Other;*
- *Maternity Care;*
- *Well Newborn Nursery Care;*
- *Treatment of Infertility; and*
- *Outpatient Prescription Drugs*

The following are not covered under this benefit:

- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA.

## **2. Physicians and Other Health Professionals**

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### **Physician and Specialist Services (Non-Surgical and Non-Preventive)**

Eligible Health Services include services provided by Your Physician to treat an Illness or Injury such as radiological supplies, services and tests. You can get those services:

- At the Physician's or Specialist's office;
- In Your home;
- From any other inpatient or outpatient facility; or
- By way of Telemedicine.

### **Allergy Testing and Treatment**

Eligible Health Services include the services and supplies that Your Physician or Specialist may provide for:

- Allergy testing;
- Allergy injections treatment; and
- Allergy sera and extracts administered via injection.

### **Physician and Specialist – Inpatient Surgical Services**

Eligible Health Services include the services of:

- The surgeon who performs Your Surgery while You are confined in a Hospital or birthing center; and
- Your surgeon who You visit before and after the Surgery.

### **Anesthetist**

Covered Benefits for Your Surgery include the services of an anesthetist who is not employed or retained by the Hospital where the Surgery is performed.

### **Surgical Assistant**

Covered Benefits for Your Surgery include the services of a surgical assistant. A “surgical assistant” is a Health Professional trained to assist in Surgery and during the periods before and after Surgery. A surgical assistant is under the supervision of a Physician.

The following are not covered under this benefit:

- The services of any other Physician who helps the operating Physician;
- A Stay in a Hospital (Hospital Stays are covered in the *Eligible Health Services and Exclusions – Hospital and Other Facility Care* section); and
- Services of another Physician for the administration of a local anesthetic.

### **Physician and Specialist – Outpatient Surgical Services**

Eligible Health Services include the services of:

- The surgeon who performs Your Surgery in the outpatient department of a Hospital or Surgery Center and
- Your surgeon who You visit before and after the Surgery.

### **Anesthetist**

Covered Benefits for Your Surgery include the services of an anesthetist who is not employed or retained by the Hospital or Surgery Center where the Surgery is performed.

### **Surgical Assistant**

Covered Benefits for Your Surgery include the services of a surgical assistant. A “surgical assistant” is a Health Professional trained to assist in Surgery and during the periods before and after Surgery. A surgical assistant is under the supervision of a Physician.

The following are not covered under this benefit:

- The services of any other Physician who helps the operating Physician;
- A Stay in a Hospital (Hospital Stays are covered in the *Eligible Health Services and Exclusions – Hospital and Other Facility Care* section);
- A separate facility charge for Surgery performed in a Physician’s office; and
- Services of another Physician for the administration of a local anesthetic.

### **In-Hospital Non-Surgical Physician Services**

During Your Stay in a Hospital for Surgery, Eligible Health Services include the services of a Physician employed by the Hospital to treat You. The Physician does not have to be the one who performed the Surgery.

### **Consultant Services (Non-Surgical and Non-Preventive)**

Eligible Health Services include the services of a consultant to confirm a diagnosis made by Your Physician or to determine a diagnosis. Your Physician or Specialist must make the request for the consultant services.

Covered Benefits include treatment by the consultant.

The consultation by a Physician or Specialist may happen by way of Telemedicine.

#### **Important note:**

Your Policy covers Telemedicine but only when You get Your consult through a Physician or Specialist that has contracted with Peak Health to offer these services. All in-person consultant office visits provided by a Physician or Specialist that are Covered Benefits are also covered if You use Telemedicine instead.

### **Second or Third Surgical Opinion**

Eligible Health Services include a second surgical opinion by a Specialist to confirm Your need for a Surgery. The Specialist must be board-certified in the medical field for the Surgery that is being proposed by Your Physician.

Covered Benefits include diagnostic lab work and radiological services ordered by the Specialist. If Your Physician and the Specialist don't agree, We will pay for a third surgical opinion. We must receive a written report from a Specialist on the second and third surgical opinion.

### **Walk-in Clinic (Non-Emergency Visit)**

Eligible Health Services include, but are not limited to, health care services provided at Walk-in Clinics for:

- Scheduled and unscheduled visits for Illnesses and Injuries that are not Emergency Medical Conditions;
- Preventive care immunizations administered within the scope of the clinic's license; and
- Preventive screening and counseling services that will help you:
  - With obesity or healthy diet; or
  - To stop using tobacco products.

### **3. Hospital and Other Facility Care**

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#### **Hospital Care – Facility Charges**

Eligible Health Services include inpatient and outpatient Hospital care.

The types of Hospital care services that are eligible for coverage include:

- Room and Board charges up to the Hospital's Semi-Private Room Rate. Your plan will cover the extra expense of a private room when appropriate because of Your medical condition;
- Services of Health Professionals employed by the Hospital;
- Operating and recovery rooms;
- Intensive Care Units of a Hospital;
- Administration of blood and blood derivatives, but not the expense of the blood or blood product;
- Radiation therapy;
- Inhalation therapy;
- Cognitive rehabilitation;
- Speech therapy, physical therapy and occupational therapy;
- Oxygen and oxygen therapy;
- Radiological services, laboratory testing and diagnostic services;
- Medications;
- Intravenous (IV) preparations;
- Discharge planning; and
- Services and supplies provided by the outpatient department of a Hospital.

#### **Preadmission Testing**

Eligible Health Services include pre-admission testing on an outpatient basis before a scheduled Surgery.

For Your preadmission testing to be eligible for coverage, the following conditions must be met:

- The testing is related to the scheduled Surgery;
- The testing is done within the 45 days before the scheduled Surgery; and
- The testing is not repeated in, or by, the Hospital or Surgery Center where the Surgery is done.

If You cancel the scheduled Surgery, We will pay Covered Benefits at the cost-sharing that applies to *Outpatient Diagnostic Testing*.

## Alternatives to Hospital Stays

### Outpatient Surgery – Facility Charges

Eligible Health Services include facility services provided and supplies used in connection with outpatient Surgery performed in a Surgery Center or a Hospital's outpatient department.

**Important note:**

Some Surgeries can be done safely in a Physician's office. For those Surgeries, Your plan will pay only for Physician services and not a separate facility fee.

The following are not covered under this benefit:

- The services of any other Physician who helps the operating Physician;
- A Stay in a Hospital (See the *Hospital Care – Facility Charges* benefit in this section);
- A separate facility charge for Surgery performed in a Physician's office; or
- Services of another Physician for the administration of a local anesthetic.

### Home Health Care

Eligible Health Services include home health care services provided by a Home Health Care Agency in the home, but only when all of the following criteria are met:

- You are Homebound;
- Your Physician orders them;
- The services take the place of Your needing to Stay in a Hospital or a Skilled Nursing Facility, or needing to receive the same services outside Your home;
- The services are part of a Home Health Care Plan;
- The services are Skilled Nursing Services, Home Health Aide services or medical social services, or are short-term speech, physical or occupational therapy;
- Home Health Aide services are provided under the supervision of a registered nurse; and
- Medical social services are provided by or supervised by a Physician or social worker.

Short-term physical, speech and occupational therapy provided in the home are subject to the conditions and limitations imposed on therapy provided outside the home. See the *Short-Term Rehabilitation Services* and *Habilitation Therapy Services* sections and the Statement of Benefits.

Home health care services do not include Custodial Care.

The following are not covered under this benefit:

- Services for infusion therapy;
- Nursing and Home Health Aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities);

- Transportation;
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present;
- Homemaker or housekeeper services;
- Food or home delivered services; or
- Maintenance therapy.

## **Hospice Care**

Eligible Health Services include inpatient and outpatient Hospice Care provided during a Hospice Benefit Period and when given as part of a Hospice Care Program because Your Physician diagnoses You with a Terminal Illness.

The types of Hospice Care services that are eligible for coverage include:

- Room and Board;
- Services and supplies furnished to You on an inpatient or outpatient basis;
- Services by a Hospice Care Agency or Hospice Care provided in a Hospital;
- Part-time or intermittent nursing care by a R.N. or L.P.N. for up to eight hours a day;
- Part-time or intermittent Home Health Aide services to care for You up to eight hours a day;
- Medical social services under the direction of a Physician such as:
  - Assessment of Your social, emotional and medical needs, and Your home and family situation;
  - Identification of available community resources; or
  - Assistance provided to You to obtain resources to meet Your assessed needs; and
- Respite Care.

Hospice Care services provided by the Providers below may be covered, even if the Providers are not an employee of the Hospice Care Agency responsible for Your care:

- A Physician for consultation or case management;
- A physical or occupational therapist; and
- A Home Health Care Agency for:
  - Physical and occupational therapy;
  - Medical supplies;
  - Outpatient Prescription Drugs;
  - Psychological counseling; or
  - Dietary counseling.

The following are not covered under this benefit:

- Funeral arrangements;
- Pastoral counseling;
- Bereavement counseling;
- Financial or legal counseling which includes estate planning and the drafting of a will; or
- Homemaker or caretaker services that are services which are not solely related to Your care and may include:
  - Sitter or companion services for either You or other family members;
  - Transportation; or
  - Maintenance of the house.

### **Outpatient Private Duty Nursing**

Eligible Health Services include private duty nursing care provided by an R.N. or L.P.N. for non-hospitalized acute Illness or Injury if Your condition requires skilled nursing care and visiting nursing care is not adequate.

### **Skilled Nursing Facility**

Eligible Health Services include inpatient Skilled Nursing Facility care.

The types of Skilled Nursing Facility care services that are eligible for coverage include:

- Room and Board, up to the Semi-Private Room Rate; and
- Services and supplies that are provided during Your Stay in a Skilled Nursing Facility.

For Your Stay in a Skilled Nursing Facility to be eligible for coverage, the following conditions must be met:

- The Skilled Nursing Facility admission will take the place of:
  - An admission to a Hospital or sub-acute facility; or
  - A continued Stay in a Hospital or sub-acute facility;
- There is a reasonable expectation that Your condition will improve enough to go home within a reasonable amount of time; and
- The Illness or Injury is severe enough to require constant or frequent skilled nursing care on a 24-hour basis.

#### **Important note:**

We cover home short-term physical, speech, or occupational therapy when the Skilled Nursing Facility criteria above are met.

## **4. Emergency Services and Urgent Care**

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Eligible Health Services include services and supplies for the treatment of an Emergency Medical Condition or an Urgent Condition.

Emergency Services coverage for an Emergency Medical Condition includes Your use of:

- An Ambulance;
- The emergency room facilities;
- The emergency room staff Physician services;
- The Hospital nursing staff services; and
- The staff radiologist and pathologist services.

As always, You can get Emergency Services from In-Network Providers. However, You can also get Emergency Services from Out-of-Network Providers.

Your coverage for Emergency Services will continue until the following conditions are met:

- You are evaluated and Your condition is stabilized; and
- Your attending Physician determines that You are medically able to travel or be transported, by non-medical or non-emergency transportation, to another Provider if You need more care.

For follow-up care, You are covered when:

- Your in-network Physician provides the care;

### **In Case of a Medical Emergency**

When You experience an Emergency Medical Condition , You should go to the nearest emergency room. You can also dial 911 or Your local emergency response service for medical and Ambulance assistance. If possible, call Your Physician but only if a delay will not harm Your health.

### **Non-Emergency Condition**

If You go to an emergency room for what is not an Emergency Medical Condition, the plan will not cover Your expenses. See the Statement of Benefits for specific plan details.

The following are not covered under this benefit:

- Non-emergency services in a Hospital emergency room facility.

### **In Case of an Urgent Condition**

#### **Urgent Condition**

If You need care for an Urgent Condition, You should first seek care through Your Physician . If Your Physician is not reasonably available to provide services, You may access urgent care from an Urgent Care Facility.

#### **Non-Urgent Condition**

If You go to an Urgent Care Facility for what is not an Urgent Condition, the plan will not cover

Your expenses. See the Statement of Benefits for specific plan details.

Examples of non-urgent care are:

- Routine or preventive care (this includes immunizations);
- Follow-up care;
- Physical therapy;
- Elective treatment; and
- Any diagnostic lab work and radiological services which are not related to the treatment of the Urgent Condition.

Non-urgent care in an Urgent Care Facility (at a non-hospital freestanding facility) is not covered under this benefit.

## 5. Pediatric Dental Care

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Eligible Health Services include dental services and supplies provided by a Dental Provider as found in the *Pediatric Dental Care* section of the Statement of Benefits.

### Dental Emergencies

Eligible Health Services also include dental services provided for a Dental Emergency. Services and supplies provided for a Dental Emergency will be covered even if services and supplies are provided by an Out-of-Network Provider.

If You have a Dental Emergency, You should consider calling Your In-Network Dental Provider who may be more familiar with Your dental needs. If You cannot reach Your In-Network Dental Provider, You may get treatment from any Dentist. The care received from an Out-of-Network Provider must be for the temporary relief of the Dental Emergency until You can be seen by Your In-Network Dental Provider. Services given for other than the temporary relief of the Dental Emergency by an Out-of-Network Provider may not be covered. To get the maximum level of benefits, services should be provided by Your In-Network Dental Provider.

If You get treatment from an Out-of-Network Provider for a Dental Emergency, the plan pays a benefit at the in-network cost-sharing level of coverage.

Follow-up care will be paid at the cost-sharing level that applies to the type of Provider that gives You the care.

### Orthodontic Treatment

Orthodontic treatment is covered for a severe, dysfunctional, disabling condition, such as:

- Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement;
- The following craniofacial anomalies:
  - Hemifacial microsomia;
  - Craniosynostosis syndromes;
  - Cleidocranial dental dysplasia;
  - Arthrogryposis; or
  - Marfan syndrome;
- Anomalies of facial bones and/or oral structures; and
- Facial trauma resulting in functional difficulties.

If You suffer from one of these conditions, the orthodontic services that are eligible for

coverage include:

- Pre-orthodontic treatment visit;
- Comprehensive orthodontic treatment; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

## **Replacements**

The “replacement rule” means that replacements of, or additions to, these dental services are covered only when:

- You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, You need to replace or add teeth to Your denture or bridge;
- The present crown, inlay, onlay and veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 years before its replacement and cannot be fixed; or
- You had a tooth (or teeth) extracted. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

The plan’s “replacement rule” applies to:

- Crowns;
- Inlays;
- Onlays;
- Veneers;
- Complete dentures;
- Removable partial dentures;
- Fixed partial dentures (bridges); and
- Other prosthetic services.

## **Missing Teeth that are not Replaced**

The plan covers installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth. (The extraction of a third molar tooth does not qualify.); or
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years.

Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

## **Advance Claim Review**

This only applies to out-of-network coverage. The purpose of the advance claim review is to determine, in advance, what We will pay for proposed services. Knowing ahead of time which services are covered and the benefit amount payable, helps You and Your Dental Provider make informed decisions about the care You are considering.

**Important note:**

The advance claim review is not a guarantee of coverage and payment, but rather an estimate of the amount or scope of benefits to be paid.

**When to get an Advance Claim Review**

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than \$1,000. Here are the steps to get an advance claim review:

1. Ask Your Dental Provider to write down a full description of the treatment You need, using either an Peak Health claim form or an American Dental Association (ADA) approved claim form;
2. Before treating you, Your Dental Provider should send the form to Us;
3. We may request supporting images and other diagnostic record;
4. Once all of the information has been gathered, We will review the proposed treatment plan and provide You and Your Dental Provider with a statement outlining the benefits payable; and
5. You and Your Dental Provider can then decide how to proceed.

The advance claim review is voluntary. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, We will take into account alternate procedures, services, or courses of dental treatment for the dental condition in question in order to accomplish the anticipated result. See the *When Does Your Plan Cover Other Treatment?* section below.

**Course of Dental Treatment**

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more Dentists to treat a dental condition that was diagnosed by the attending Dentist during an oral examination. A course of treatment starts on the date Your Dentist first renders a service to correct or treat the diagnosed dental condition.

**When Does Your Plan Cover Other Treatment?**

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

If a charge is made for a non-eligible health service and an Eligible Health Service would provide an acceptable result, then Your plan will pay a benefit for the Eligible Health Service.

When alternate services or supplies can be used, the plan's coverage will be limited to the expense of the least expensive service or supply that is:

- Customarily used nationwide for treatment; and

- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account Your current oral condition.

You should review the differences in the expense of alternate treatment with Your Dental Provider. Of course, You and Your Dental Provider can still choose the more expensive treatment method. You are responsible for any charges in excess of what the plan will cover.

## **Pediatric Dental Care Exclusions**

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene;
- Asynchronous dental treatment;
- Cosmetic services and supplies including:
  - Plastic Surgery, reconstructive Surgery, cosmetic Surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance;
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Eligible Health Services and Exclusions* section; and
  - Facings on molar crowns and pontics will always be considered Cosmetic;
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic Injury and teeth cannot be restored with a filling material; or
  - The tooth is an abutment to a covered partial denture or fixed bridge;
- Dental implants and braces (that are determined not to be Medically Necessary), mouth guards, and other devices to protect, replace or reposition teeth;
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting;
  - To alter vertical dimension;
  - To restore occlusion; or
  - For correcting attrition, abrasion, abfraction or erosion;
- Treatment of any Jaw Joint Disorder and treatments to alter bite or the alignment or operation of the jaw, including Temporomandibular Joint Dysfunction disorder (TMJ) and Craniomandibular Joint Dysfunction disorder (CMJ) treatment, orthognathic Surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible Health Services and Exclusions – Specific Conditions* section;
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another Eligible Health Service;
  - Seven years of age or younger or is developmentally disabled and is an individual

- for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the enrollee or insured and for whom a superior result can be expected from dental care provided under general anesthesia; or
- A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.
- Mail order and at-home kits for orthodontic treatment;
  - Orthodontic treatment except as covered above and in the *Pediatric Dental Care* section of the Statement of Benefits;
  - Pontics, crowns, cast or processed restorations made with high noble metals (gold);
  - Prescribed drugs, pre-medication or analgesia (nitrous oxide);
  - Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures;
  - Replacement of teeth beyond the normal complement of 32;
  - Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric Dental Care* section of the Statement of Benefits;
  - Services and supplies:
    - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services;
    - Provided for Your personal comfort or convenience or the convenience of another person, including a Provider;
    - Provided in connection with treatment or care that is not covered under Your Policy;
  - Surgical removal of impacted wisdom teeth only for orthodontic reasons; and
  - Treatment by other than a Dental Provider.

## **6. Specific Conditions**

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### **Diabetic Services and Supplies (including Equipment and Training)**

This coverage includes the treatment of insulin dependent (type I), non-insulin dependent (type II) diabetes, and the treatment of elevated blood glucose levels during pregnancy.

Eligible Health Services include:

- Services and supplies:
  - Foot care to minimize the risk of infection;
  - Insulin preparations;
  - Hypodermic needles, syringes and pens used for the treatment of diabetes;
  - Injection aids for the blind;
  - Diabetic test agents;
  - Lancet devices and kits;
  - Prescribed oral medications whose primary purpose is to influence blood sugar;
  - Alcohol swabs;
  - Injectable glucagons; and
  - Glucagon emergency kits;
- Equipment:
  - External insulin pumps and pump supplies;
  - Blood glucose meters without special features, unless required due to blindness; and
  - Foot orthotic devices including orthopedic shoes and shoe inserts; and
- Training:
  - Self-management training provided by a health care Provider certified in diabetes self-management training.

“Self-management training” is a day care program of educational services and self-care designed to instruct You in the self-management of diabetes (including medical nutritional therapy). The program must be under the supervision of a Health Professional whose scope of practice includes diabetic education or management.

### **Temporomandibular Joint Dysfunction Treatment (TMJ) and Craniomandibular Joint Dysfunction Treatment (CMJ)**

Eligible Health Services for the treatment of TMJ and CMJ include the following services provided by a Provider:

- Diagnostic or therapeutic services including treatment of associated myofascial pain;
- Medical and dental surgical treatment; and
- Medical and dental non-surgical treatment including prosthesis placed directly on the teeth.

The following are not covered under this benefit:

- Dental implants.

### **Accidental Injury to Sound Natural Teeth**

Dental Services will be covered only when due to an accidental injury to the jaws, sound natural teeth, mouth or face. Such Services must be Incurred within one year from the date of the accident. Injury as a result of chewing or biting shall not be considered an accidental injury.

Eligible Health Services include the services and supplies of a Dental Provider to treat an Injury to Sound Natural Teeth.

The following are not covered under this benefit:

- The care, filling, removal or replacement of teeth and treatment of diseases of the teeth;
- Dental services related to the gums;
- Apicoectomy (dental root resection);
- Orthodontics;
- Root canal treatment;
- Soft tissue impactions;
- Bony impacted teeth;
- Alveolectomy;
- Augmentation and vestibuloplasty treatment of periodontal disease;
- False teeth;
- Prosthetic restoration of dental implants; and
- Dental implants.

### **Dermatological Treatment**

Eligible Health Services include the diagnosis and treatment of skin disorders by a Physician or Specialist.

The following are not covered under this benefit:

- Cosmetic treatment and procedures.

### **Autism Spectrum Disorder**

Autism Spectrum Disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

Eligible Health Services include the services and supplies provided by a Physician or Behavioral Health Provider for the diagnosis, testing and treatment of autism spectrum disorders. We will only cover this treatment if a Physician or Behavioral Health Provider orders it as part of a treatment plan.

We will cover certain early intensive behavioral interventions such as applied behavior analysis (ABA). Applied behavior analysis is an educational service that is the process of applying interventions that:

- systematically change behavior; or
- are responsible for observable improvements in behavior.

**Important note:**

As a reminder, applied behavior analysis requires Precertification by Peak Health. Your In-Network Provider is responsible for obtaining Precertification. You are responsible for obtaining Precertification when you use an Out-of-Network Provider.

## **Mental Health Disorders Treatment**

Eligible Health Services include the treatment of Mental Health Disorders provided by a general medical Hospital, Psychiatric Hospital, Residential Treatment Facility, Physician, or Behavioral Health Provider as follows:

- Inpatient Room and Board at the Semi-Private Room Rate. Your plan will cover the extra expense of a private room when appropriate because of Your medical condition;
- Other services and supplies related to Your condition that are provided during Your Stay in a general medical Hospital, Psychiatric Hospital, or Residential Treatment Facility;
- Outpatient treatment received while not confined as an inpatient in a general medical Hospital, Psychiatric Hospital, or Residential Treatment Facility, including:
  - Office visits to a Physician or Behavioral Health Provider such as a Psychiatrist, psychologist, social worker, or licensed professional counselor (includes Telemedicine consultations);
  - Individual, group and family therapies for the treatment of mental health; and
  - Other outpatient mental health treatment such as:
    - Partial Hospitalization Treatment provided in a facility or program for mental health treatment provided under the direction of a Physician;
    - Intensive Outpatient Program provided in a facility or program for mental health treatment provided under the direction of a Physician;
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are Homebound;
      - Your Physician orders them;
      - The services take the place of a Stay in a Hospital or a Residential Treatment Facility, or You are unable to receive the same services outside Your home; and
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease;
    - Electro-convulsive therapy (ECT);
    - Transcranial magnetic stimulation (TMS);
    - Psychological testing;

- Neuropsychological testing; and
- Peer counseling support by a peer support specialist (including Telemedicine consultation) where the peer support specialist serves as a role model, mentor, coach, and advocate. Peer support must be supervised by a Behavioral Health Provider.

## **Substance Related Disorders Treatment**

Eligible Health Services include the treatment of Substance Related Disorders provided by a general medical Hospital, Psychiatric Hospital, Residential Treatment Facility, Physician, or Behavioral Health Provider as follows:

- Inpatient Room and Board at the Semi-Private Room Rate. Your plan will cover the extra expense of a private room when appropriate because of Your medical condition;
- Other services and supplies that are provided during Your Stay in a general medical Hospital, Psychiatric Hospital or Residential Treatment Facility; and
- Outpatient treatment received while not confined as an inpatient in a general medical Hospital, Psychiatric Hospital or Residential Treatment Facility, including:
  - Office visits to a Physician or Behavioral Health Provider such as a Psychiatrist, psychologist, social worker, or licensed professional counselor (includes Telemedicine consultations);
  - Individual, group and family therapies for the treatment of Substance Related Disorders;
  - Other outpatient Substance Related Disorders treatment such as:
    - Outpatient Detoxification;
    - Partial Hospitalization Treatment provided in a facility or program for treatment of Substance Related Disorders provided under the direction of a Physician;
    - Intensive Outpatient Program provided in a facility or program for treatment of Substance Related Disorders provided under the direction of a Physician;
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are Homebound;
      - Your Physician orders them;
      - The services take the place of a Stay in a Hospital or a Residential Treatment Facility, or You are unable to receive the same services outside Your home; or;
      - The skilled behavioral health care is appropriate for the active treatment of a condition, Illness, or disease;
- Ambulatory Detoxification which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications;
- Treatment of withdrawal symptoms; and
- Peer counseling support by a peer support specialist (including Telemedicine consultation) where a peer support specialist serves as a role model, mentor, coach, and advocate. Peer support must be supervised by a Behavioral Health Provider.

**Important note:**

Your Policy covers Telemedicine for Mental Health Disorders and Substance Related Disorders but only when You get Your consult through a Physician or Behavioral Health Provider that has contracted with Peak Health to offer these services. All in-person Physician or Behavioral Health Provider office visits that are Covered Benefits are also covered if You use Telemedicine provided by a Physician or Behavioral Health Provider instead.

## **Obesity (Bariatric) Surgery and Services**

Eligible Health Services include obesity Surgery, which is also known as “weight loss Surgery.” Obesity Surgery is a type of procedure performed on people who are Morbidly Obese, for the purpose of losing weight.

Obesity is typically diagnosed based on Your Body Mass Index (BMI). To determine whether You qualify for obesity Surgery, Your Physician will consider Your BMI and any other condition or conditions You may have. In general, obesity Surgery will not be approved for any Covered Person with a BMI less than 35.

Your Physician will request approval from Us in advance of Your obesity Surgery. We will cover charges made for the following outpatient weight management services:

- An initial medical history and physical exam;
- Diagnostic tests given or ordered during the first exam;
- Outpatient Prescription Drug benefits included under the *Outpatient Prescription Drugs* section; and
- Other related outpatient services.

Health care services include one obesity Surgical Procedure. However, Eligible Health Services also include a multi-stage procedure when planned and approved by us. Your health care services include adjustments after an approved lap band procedure. This includes approved adjustments in an office or outpatient setting.

The following are not covered under this benefit:

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including Morbid Obesity except as described above and in the *Eligible Health Services and Exclusions – Preventive Care and Wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications;
  - Hypnosis or other forms of therapy; and
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

## **Reconstructive Surgery and Supplies**

Eligible Health Services include all stages of reconstructive Surgery by Your Provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your Surgery reconstructs the breast where a necessary mastectomy was performed. Services and supplies include:
  - An implant;
  - Areolar and nipple reconstruction;
  - Areolar and nipple re-pigmentation;
  - Surgery on a healthy breast to make it symmetrical with the reconstructed breast; and
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema and prosthetic devices.
- Your Surgery is to implant or attach a covered prosthetic device;
- Your Surgery corrects a gross anatomical defect present at birth. The Surgery will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part;
  - The purpose of the Surgery is to improve function; and
- Your Surgery is needed because treatment of Your Illness resulted in severe facial disfigurement or major functional impairment of a body part, and Your Surgery will improve function.

## **Transplant Services**

Eligible Health Services include transplant services provided by a Physician and Hospital.

This includes the following transplant types:

- Solid organ;
- Hematopoietic stem cell;
- Bone marrow;
- CAR-T and T Cell receptor therapy for FDA-approved treatments; and
- Thymus tissue for FDA-approved treatments.

## **Network of Transplant Facilities**

We may designate facilities to provide specific services or procedures. They are listed in Your Provider Directory.

You must get transplant services from the facility We designate to perform the transplant You need. Transplant services received are subject to the in-network Copayment, Coinsurance, Policy Year Deductible, maximum out-of-pocket and limits, unless stated differently in this certificate and the Statement of Benefits.

The amount You will pay for covered transplant services depends on where You get the care. Your cost share will be lower when You get transplant services from a facility We designate to perform the transplant You need. Transplant services received are subject to the in-network Copayment, Coinsurance, Policy Year Deductible, maximum out-of-pocket and limits, unless stated differently in this certificate and the Statement of Benefits.

### **Travel and Lodging Expenses**

Travel Reimbursement for transplants that occur at a facility that is located greater than 100 miles from the recipient's home, the following will be covered during the reimbursement period:

- Reimbursement applies to recipient (adult) and one other person. If the recipient is a minor, two adults are covered. Collectively considered the reimbursement party, separately considered individual.
- \$150/day limit lodging and meals per reimbursement party;
- Ground travel is reimbursed based on the mileage from the recipient's home or temporary lodging to the transplant Facility. Reimbursement is calculated using federal mileage reimbursement rate per individual;
- Air travel is reimbursed at the price of the airline ticket (coach class) per individual;
- Tolls and parking Incurred while traveling between recipient's home or temporary lodging and transplant Facility per individual;
- There is a \$10,000 aggregate limit for all travel costs per reimbursement party; and
- The reimbursement period begins 5 days prior to a transplant and ends 6 months after the date of transplant.

#### **Important note:**

If there are no facilities assigned to perform Your transplant type in Your network, it's important that you contact us so We can help you determine if there are other facilities that may meet Your needs. If you don't get Your transplant services at the facility We designate they will not be Eligible Health Services.

Many pre- and post-transplant medical services, even routine ones, are related to and may affect the success of Your transplant.

### **Other Transplants**

Eligible Health Services include corneal (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants. Corneal and cartilage transplants may not be available at certain facilities.

The following are not covered under this benefit:

- Services and supplies furnished to a donor when the recipient is not a Covered Person;
- Harvesting and storage of organs, without intending to use them for immediate transplantation for Your existing illness; or
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from

harvesting, for an existing illness.

## **Maternity Care**

Eligible Health Services include prenatal (non-preventive care), delivery, postpartum care, and other obstetrical services, and postnatal visits. Coverage includes Eligible Health Services provided by a licensed mid-wife.

After Your child is born, Eligible Health Services include:

- 48 hours of inpatient care in a Hospital or birthing center after a vaginal delivery;
- 96 hours of inpatient care in a Hospital or birthing center after a cesarean delivery;
- A shorter Stay if the attending Physician, with the consent of the mother, discharges the mother or newborn earlier; and

The following are not covered under this benefit:

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries.

## **Well Newborn Nursery Care**

Eligible Health Services include routine care of Your well newborn child in a Hospital or birthing center such as:

- Well newborn nursery care during the mother's Stay but for not more than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery;
- Services and supplies needed for circumcision by a Provider; and
- Newborn children are covered for the first 31 days following birth. To continue coverage for newborn children after this period, please refer to the *Adding New Dependents* section for more information.

## **Birthing Center - Facility Charges**

Eligible Health Services include prenatal (non-preventive care) and postpartum care and obstetrical services from a birthing center.

A birthing center is a facility specifically licensed as a freestanding birthing center by applicable state and federal laws to provide prenatal care, delivery and immediate postpartum care.

Refer to the *Eligible Health Services and Exclusions – Maternity Care* and *Well Newborn Nursery Care* sections for more information.

## **Family Planning Services – Other**

Eligible Health Services include certain family planning services provided by Your Physician such as:

- Voluntary sterilization for males;
- Abortion to the extent the pregnancy is the result of rape or incest or if it places the woman's

life in serious danger

The following are not covered under this benefit:

- Reversal of voluntary sterilization procedures, including related follow-up care; or
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care.

## **Treatment of Infertility**

### **Basic Infertility Services**

Eligible Health Services include seeing a Physician or Infertility Specialist to:

- diagnose and evaluate the underlying medical cause of Infertility; and
- Perform Surgery to treat the underlying medical cause of Infertility, such as endometriosis Surgery or, for men, varicocele Surgery.

The Plan covers services for the diagnosis and treatment of the underlying causes of infertility provided by or under the direction of a Network Provider. Covered Services include Medically Necessary treatment and procedures that treat a medical condition that results in infertility (e.g., endometriosis, blockage of fallopian tubes, varicocele, etc.).

The following are not covered under the Infertility treatment benefit:

- All charges associated with:
  - Surrogacy for You or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father;
  - Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue;
  - Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue;
  - The care of the donor in a donor egg cycle which includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers;
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which the person is not genetically related; and
  - Obtaining sperm from a person not covered under this plan for ART services;
- Home ovulation prediction kits or home pregnancy tests;
- The purchase of donor embryos, donor oocytes, or donor sperm;
- Reversal of voluntary sterilizations, including follow-up care;
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures; and
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery; and

- ART services

## 7. Specific Therapies and Tests

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### Outpatient Diagnostic Testing

#### Diagnostic Complex Imaging Services

Eligible Health Services include complex imaging services by a Provider, including:

- Computed tomography (CT) scans;
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA);
- Nuclear medicine imaging including positron emission tomography (PET) scans; and
- Other outpatient diagnostic imaging service where the billed charge exceeds \$500.

#### Diagnostic Lab Work and Radiological Services

Eligible Health Services include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests.

### Chemotherapy

Eligible Health Services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, Your Hospital benefit covers the initial dose of chemotherapy after a cancer diagnosis during a Hospital Stay. Covered Benefits for chemotherapy include anti-nausea Prescription Drugs and FDA approved Cooling Caps used during chemotherapy to help reduce hair loss used in an appropriate infusion setting.

### Lyme Disease

Eligible Health Services for Lyme disease includes long-term antibiotic therapy for treatment of Lyme disease when such treatment is determined to be Medically Necessary and ordered by a Physician after making a thorough evaluation of Your symptoms, diagnostic test results, or response to treatment.

### Outpatient Infusion Therapy

Eligible Health Services include infusion therapy You receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility;
- The outpatient department of a Hospital;
- A Physician in their office; and
- A home care Provider in Your home.

You can access the list of in-network infusion locations by contacting Member Services at the toll-free number on Your ID card in the *How to Contact Us for Help* section or by logging in to Your Peak Health website at [peakhealth.org](http://peakhealth.org).

Infusion therapy is the parenteral (e.g. intravenous) administration of prescribed medications or

solutions.

Certain infused medications may be covered under the outpatient Prescription Drug coverage. You can access the list of Prescription Drugs by contacting Member Services at the toll-free number on Your ID card in the *How to Contact Us for Help* section or by logging in to Your Peak Health website at [peakhealth.org](http://peakhealth.org) to determine if coverage is under the outpatient Prescription Drug benefit of this Certificate of Coverage.

When Infusion therapy services and supplies are provided in Your home, they will not count toward any applicable home health care maximums.

The following are not covered under this benefit:

- Drugs that are covered under Your outpatient Prescription Drug plan;
- Enteral nutrition;
- Blood transfusions and blood products; and
- Dialysis.

## **Outpatient Radiation Therapy**

Eligible Health Services include the following radiology services provided by a Health Professional:

- Radiological services;
- Gamma ray;
- Accelerated particles;
- Mesons;
- Neutrons;
- Radium; and
- Radioactive isotopes.

## **Outpatient Prescription Drugs**

Eligible Health Services include Prescription Drugs when they are:

- Purchased by Your Provider;
- Injected or infused by Your Provider in an outpatient setting such as:
  - A free-standing outpatient facility;
  - The outpatient department of a Hospital;
  - A Physician in his/her office; or
  - A home care Provider in Your home;
- Listed on Our Prescription Drug list as covered under this Certificate of Coverage.

You can access the list of Prescription Drugs by contacting Member Services at the toll-free number on Your ID card in the *How to Contact Us for Help* section or by logging in to Your

Peak Health website at [peakhealth.org](http://peakhealth.org) to determine if coverage is under the outpatient Prescription Drug benefit of this Certificate of Coverage.

Certain injected and infused medications may be covered under the outpatient Prescription Drug coverage. You can access the list of Prescription Drugs by contacting Member Services at the toll-free number on Your ID card in the *How to Contact Us for Help* section or by logging in to Your Peak Health website at [peakhealth.org](http://peakhealth.org) to determine if coverage is under the outpatient Prescription Drug benefit of this Certificate of Coverage.

When injectable or infused services and supplies are provided in Your home, they will not count toward any applicable home health care maximums.

### **Outpatient Respiratory Therapy**

Eligible Health Services include outpatient respiratory therapy services You receive at a Hospital, Skilled Nursing Facility or Physician's office but only if those services are part of a treatment plan determined by Your risk level and ordered by Your Physician.

### **Transfusion or Kidney Dialysis of Blood**

Eligible Health Services include services and supplies for the transfusion or kidney dialysis of blood. Covered Benefits include:

- Whole blood;
- Blood components; or
- The administration of whole blood and blood components.

### **Short-Term Cardiac and Pulmonary Rehabilitation Services**

Eligible Health Services include the cardiac and pulmonary rehabilitation services listed below.

#### **Cardiac Rehabilitation**

Eligible Health Services include cardiac rehabilitation services You receive at a Hospital, Skilled Nursing Facility or Physician's office, but only if those services are part of a treatment plan determined by Your risk level and ordered by Your Physician.

#### **Pulmonary Rehabilitation**

Eligible Health Services include pulmonary rehabilitation services as part of Your inpatient Hospital Stay if it is part of a treatment plan ordered by Your Physician.

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is performed at a Hospital, Skilled Nursing Facility, or Physician's office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by Your Physician.

## **Short-term Rehabilitation and Habilitation Therapy Services**

### **Short-Term Rehabilitation Therapy Services**

Short-term rehabilitation therapy services help You restore or develop skills and functioning for daily living.

Eligible Health Services include short-term rehabilitation therapy services Your Physician prescribes. The services have to be performed by a:

- licensed or certified physical, occupational or speech therapist;
- Hospital, Skilled Nursing Facility, or Hospice Facility;
- Home Health Care Agency; or
- Physician.

Short-term rehabilitation therapy services have to follow a specific treatment plan, ordered by Your Physician.

### **Outpatient Cognitive Rehabilitation, Physical, Occupational, and Speech Therapy**

Eligible Health Services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute Illness, Injury or Surgical Procedure;
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Significantly improve, develop or restore physical functions You lost as a result of an acute Illness, Injury or Surgical Procedure; or
  - Relearn skills so You can significantly improve Your ability to perform the activities of daily living on Your own;
- Speech therapy, but only if it is expected to:
  - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute Illness, Injury or Surgical Procedure; or
  - Improve delays in speech function development caused by a gross anatomical defect present at birth; and
- Cognitive rehabilitation therapy associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy; and
  - The therapy is coordinated with Us as part of a treatment plan intended to restore previous cognitive function.

Speech function is the ability to express thoughts, speak words and form sentences. Speech

impairment is difficulty with expressing one's thoughts with spoken words.

### **Short-Term Habilitation Therapy Services**

Short-term habilitation therapy services are services that help You keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).

Eligible Health Services include short-term habilitation therapy services Your Physician prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A Hospital, Skilled Nursing Facility, or Hospice Facility;
- A Home Health Care Agency; or
- A Physician.

Short-term habilitation therapy services have to follow a specific treatment plan, ordered by Your Physician.

### **Outpatient Physical, Occupational, and Speech Habilitation Therapy**

Eligible Health Services include:

- Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function;
- Occupational therapy (except for vocational rehabilitation or employment counseling or services provided in an educational or training setting), if it is expected to develop any impaired function; and
- Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered provided the therapy is expected to develop speech function as a result of delayed development. Speech function is the ability to express thoughts, speak words and form sentences.

### **Chiropractic Services**

Eligible Health Services include chiropractic services to correct a muscular or skeletal problem.

Your Provider must establish or approve a treatment plan that details the treatment, and specifies frequency and duration.

### **Diagnostic Testing for Learning Disabilities**

Eligible Health Services include diagnostic testing for:

- Attention deficit disorder;
- Attention deficit hyperactive disorder; and
- Dyslexia.

Once You are diagnosed with one of these conditions, the treatment is covered under the *Mental Health Disorders Treatment* section.

## **8. Other Services**

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### **Ambulance Services**

Eligible Health Services include transport by professional Ambulance services.

For Emergency Services:

- To treat You in place if the Ambulance service is coordinating through Telehealth services with a Physician or Behavioral Health Provider;
- To triage or triage and transport You to an alternative destination if the Ambulance service is coordinating through Telehealth services with a Physician or Behavioral Health Provider;
- To the first Hospital to provide Emergency Services; or
- From one Hospital to another Hospital if the first Hospital cannot provide the Emergency Services You need.

For non-emergency services:

- From Hospital to Your home or to another facility if an Ambulance is the only safe way to transport You; or

If the Ambulance service is coordinating care through Telehealth or medical command with a Physician or Behavioral Health Provider and You decline to be transported against medical advice, that transportation will still be considered an Eligible Health Service.

Your plan also covers transportation to a Hospital by professional air or water Ambulance when:

- Professional ground Ambulance transportation is not available;
- Your condition is unstable, and requires medical supervision and rapid transport; or
- You are traveling from one Hospital to another and:
  - The first Hospital cannot provide the Emergency Services You need; and
  - The two conditions above are met.

The following are not covered under this benefit:

- Ambulance services for routine transportation to receive outpatient or inpatient care.

### **Clinical Trial Therapies – Experimental or Investigational**

Eligible Health Services include Experimental or Investigational drugs, devices, treatments or procedures from a Provider under an “approved clinical trial” only when You have cancer or Terminal Illnesses and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate; and
- We determine based on published, peer-reviewed scientific evidence that You may benefit from the treatment.

An “approved clinical trial” is a clinical trial that meets all of these criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval;
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation;
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization;
- The trial conforms to standards of the NCI or other, applicable federal organization;
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution; and
- You are treated in accordance with the protocols of that study.

### **Clinical Trials – Routine Patient Costs**

Eligible Health Services include “routine patient costs” incurred by You from a Provider in connection with participation in an “approved clinical trial” as a “qualified individual” for cancer or other life-threatening illness or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

The following are not covered under this benefit:

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs);
- Services and supplies provided by the trial sponsor without charge to you; and
- The experimental intervention itself (except Medically Necessary Category B investigational devices and promising experimental and investigational interventions for Terminal Illnesses in certain clinical trials in accordance with Peak Health’s claim policies).

### **Durable Medical Equipment (DME)**

Eligible Health Services include the expense of renting or buying DME and accessories You need to operate the item from a DME supplier. Your plan will cover either buying or renting the item, depending on which We think is more cost efficient. If You purchase DME, that purchase is only eligible for coverage if You need it for long-term use.

Coverage includes:

- One item of DME for the same or similar purpose;
- Repairing DME due to normal wear and tear. It does not cover repairs needed because of misuse or abuse;
- A new DME item You need because Your physical condition has changed. It also covers buying a new DME item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item; and
- The fitting and adjustment of such DME items.

We assume no responsibility and make no express or implied warranties concerning the outcome of any covered DME items.

We reserve the right to limit the payment of charges up to the most cost-efficient and least restrictive level of service or item that can be safely and effectively provided. It is Our decision whether to rent or purchase the DME item.

Coverage is limited to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment that You purchase or rent for personal convenience or mobility.

Your plan only covers the same type of DME that Medicare covers. But there are some DME items Medicare covers that Your plan does not.

The following are not covered under this benefit:

- Whirlpools;
- Portable whirlpool pumps;
- Sauna baths;
- Massage devices;
- Over bed tables;
- Elevators;
- Communication aids;
- Vision aids;
- Telephone alert systems; and
- Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a Physician.

## **Nutritional Counseling for Eating Disorders**

Eligible Health Services include nutritional counseling for eating disorders provided by a Health Professional.

## **Nutritional Support**

Eligible Health Services include formula and low protein modified food products ordered by a Physician for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

The following are not covered under this benefit:

- Any food item, including infant formulas, nutritional supplements, vitamins, plus Prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as described above.

## **Orthotic Devices**

Eligible Health Services include mechanical supportive devices ordered by Your Physician for the treatment of weak or muscle deficient feet.

## **Osteoporosis – Non-Preventive Care)**

Eligible Health Services include the diagnosis, treatment and management of osteoporosis by a Physician. The services include Food and Drug Administration approved technologies, including bone mass measurement.

## **Prosthetic Devices**

Eligible Health Services include the initial provision and subsequent replacement of a prosthetic device that Your Physician orders and administers.

A prosthetic device is device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of Illness or Injury or congenital defects , such as Cochlear implants.

Coverage includes:

- The prosthetic device;
- Repairing or replacing the original device You outgrow or that is no longer appropriate because Your physical condition changed;
- Replacements required by ordinary wear and tear or damage; and
- The fitting, instruction and other services (such as attachment or insertion) so You can properly use the device.

The following are not covered under this benefit:

- Services covered under any other benefit;
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace;

- Trusses, corsets, and other support items;
- Repair and replacement due to loss, misuse, abuse or theft;
- Communication aids.

## **Hearing Exams**

Eligible Health Services include hearing exams for evaluation and treatment of Illness, Injury or hearing loss when performed by a hearing Specialist.

The following are not covered under this benefit:

- Hearing exams given during a Stay in a Hospital or other facility, except those provided to newborns as part of the overall Hospital Stay.

## **Podiatric (Foot Care) Treatment**

Eligible Health Services include non-routine foot care for the treatment of Illness or Injury of the feet by Physicians and Health Professionals.

Non-routine treatment means:

- It would be hazardous for You if someone other than a Physician or Health Professional provided the care;
- You have an Illness that makes the non-routine treatment essential;
- The treatment is routine foot care but it's part of an Eligible Health Service (e.g., debriding of a nail to expose a subungual ulcer, or treatment of warts); and
- The treatment You need might cause You to have a change in Your ability to walk.

The following are not covered under this benefit:

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches;
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes;
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies; and
  - Routine pedicure services, such as cutting of nails, corns and calluses when there is no Illness or Injury of the feet.

## **Telemedicine**

Eligible Health Services include Telemedicine consultations when provided by a Physician, Specialist, Behavioral Health Provider or other Telemedicine Provider acting within the scope of their license.

Eligible Health Services for Telemedicine consultations are available from a number of different kinds of Providers under Your plan. Contact Member Service to get more information about Your options.

## **Vision Care -Pediatric Vision Care**

### **Routine Vision Exams**

Eligible Health Services include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.

### **Vision Care Services and Supplies**

Eligible Health Services include:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of Prescription contact lenses;
- Eyeglass frames, Prescription lenses or Prescription contact lenses that are identified as preferred by a vision Provider;
- Eyeglass frames, Prescription lenses or Prescription contact lenses that are identified as non-preferred by a vision Provider;
- Non-conventional Prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses;
- Aphakic Prescription lenses prescribed after cataract Surgery has been performed; and
- Low vision services including comprehensive low vision evaluations and prescribed optical devices, such as high-power spectacles, magnifiers, and telescopes.

In any one Policy Year, this benefit will cover either Prescription lenses for eyeglass frames or Prescription contact lenses, but not both.

The following are not covered under this benefit:

- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for Cosmetic purposes.

## 9. Outpatient Prescription Drugs

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### What You Need to Know About Your Outpatient Prescription Drug Benefits

Read this section carefully so that You know:

- How to access In-Network Pharmacies;
- Eligible Health Services under Your outpatient Prescription Drug benefit;
- What outpatient Prescription Drugs are covered;
- Other services;
- How You get an emergency Prescription filled;
- Where Your Statement of Benefits fits in;
- What Precertification requirements apply; and
- How do I request a medical exception.

Some Prescription Drugs may not be covered or coverage may be limited. This does not keep You from getting Prescription Drugs that are not Covered Benefits. You can still fill Your Prescription, but You have to pay for it Yourself. For more information see the *Where Your Statement of Benefits Fits In* section and see the Statement of Benefits.

A Pharmacy may refuse to fill a Prescription order or refill when in the professional judgment of the pharmacist the Prescription should not be filled. In this situation, the pharmacist will call the Prescriber for guidance.

Your plan provides standard safety checks to encourage safe and appropriate use of medications. These checks are intended to avoid adverse events and align with the medication's FDA-approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

### How to Access In-Network Pharmacies

#### How do You find an In-Network Pharmacy?

You can find an In-Network Pharmacy in two ways:

- **Online:** By logging in to the Navitus member portal at [memberportal.navitus.com](https://memberportal.navitus.com)
- **By phone:** Call Navitus Customer Care at 844-268-9789

During regular business hours, a Navitus Customer Care representative can assist You. You may go to any Navitus In-Network Pharmacies.

If You fail to obtain Your Prescriptions at the designated In-Network Pharmacy, Your Prescriptions will not be covered as Eligible Health Services under the plan.

The In-Network Pharmacy will submit Your claim. You will pay any cost sharing directly to the In-Network Pharmacy.

## **Eligible Health Services under Your Outpatient Prescription Drug Benefit**

### **What does Your Outpatient Prescription Drug Benefit Cover?**

Eligible Health Services under Your outpatient Prescription Drug benefit includes any Pharmacy service that meets these three requirements:

- They are described in this section;
- They are not listed as exclusions in this section or the *General Exclusions* section; and
- They are not beyond any limits in the Statement of Benefits.

Your plan benefits are covered when You follow the plan's general rules:

- You need a Prescription from Your Prescriber;
- Your drug needs to be Medically Necessary for Your Illness or Injury. See the *Medical Necessity and Precertification Requirements* section; and
- You need to show Your ID card to the Pharmacy when You get a Prescription filled.

Your outpatient Prescription Drug benefit includes drugs listed in the Navitus Marketplace Select Formulary Prescription Drugs not in the Navitus Marketplace Select Formulary are excluded unless a medical exception is approved by Navitus prior to the Prescription Drug being picked up at the Pharmacy. If it is Medically Necessary for You to use a Prescription Drug not on the Navitus Marketplace Select Formulary You or Your Prescriber must request a medical exception. See the *How can I Request a Medical Exception* section.

Generic Prescription Drugs may be substituted by Your pharmacist for Brand-Name Prescription Drug. Your out-of-pocket costs may be less if You use a Generic Prescription Drug when available.

Prescription Drugs covered by this plan are subject to misuse, waste, and/or abuse utilization review by us, Your Provider, and/or Your In-Network Pharmacy. The outcome of this review may include: limiting coverage of the applicable drug(s) to one prescribing Provider and/or one In-Network Pharmacy, limiting the quantity, dosage, day supply, requiring a partial fill or denial of coverage.

### **What Outpatient Prescription Drugs are Covered?**

Your Prescriber may give You a Prescription in different ways, including:

- Writing out a Prescription that You then take to a Pharmacy;
- Calling or e-mailing a Pharmacy to order the medication; and
- Submitting Your Prescription electronically to a Pharmacy.

Once You receive a Prescription from Your Prescriber, You may fill the Prescription at a In-Network Retail, Mail Order or Specialty Pharmacy.

## **Prescription Drug Synchronization**

If You are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for Your convenience, Your In-Network Pharmacy may be able to coordinate that for You. We will apply a prorated daily cost share rate to a partial fill of a maintenance drug, if needed, to synchronize Your Prescription Drugs.

## **Types of Pharmacies**

### **Retail Pharmacy**

Generally, Retail Pharmacies may be used for up to a 90 day supply of Prescription Drugs. You should show Your ID card to the Navitus In-Network Pharmacy every time You get a Prescription filled.

You do not have to complete or submit claim forms. The Navitus In-Network Pharmacy will take care of claim submission. You may have to complete or submit claim forms when You use an Out-of-Network Pharmacy.

### **Mail Order Pharmacy**

Generally, the drugs available through mail order are maintenance drugs that You take on a regular basis for a chronic or long-term medical condition.

Outpatient Prescription Drugs are covered when dispensed by a Navitus in-network Mail Order Pharmacy. A Mail Order Pharmacy may be used for up to a 90-day supply of Prescription Drugs. Prescriptions for more than a 90 day supply are not eligible for coverage when dispensed by a Navitus in-network pharmacy.

### **Specialty Pharmacy**

You may fill up to a 30 day supply of a Specialty Prescription Drug. You can access the list of Specialty Prescription Drugs by contacting Navitus at 844-268-9789 on Your ID card or by logging in to the Navitus member portal at [memberportal.Navitus.com](https://memberportal.Navitus.com).

Specialty Prescription Drugs are covered when dispensed through a Navitus in-network Pharmacy. All Specialty Prescription Drugs fills including the initial fill must be filled at an in-network Pharmacy except for urgent situations.

See the Statement of Benefits for details on supply limits and cost sharing.

### **Specialty Split Fill Program**

This program provides patients that are prescribed certain Prescription Drugs with a partial fill to make sure they tolerate the drug without harmful impacts. The drugs in this program have a higher instance of intolerance. This program helps reduce potential waste by having You try the drug first. Your cost share will be prorated accordingly. You can access the list of these Prescription Drugs by contacting Navitus Customer Care at 844-268-9789 or by logging in to Your Navitus member portal [memberportal.navitus.com](https://memberportal.navitus.com)

Some Specialty Prescription Drugs may qualify for third-party Copayment assistance programs that could lower Your out-of-pocket costs. Any manufacturer coupon or rebate assistance amount received through one of these programs will not apply towards Your Deductible or Maximum Out-of-Pocket Limit.

## **Other Outpatient Prescription Drug Services**

### **Preventive Contraceptives**

For females who are able to reproduce, Your outpatient Prescription Drug plan covers certain

Prescription Drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a Prescriber and the Prescription is submitted to the pharmacist for processing. Your outpatient Prescription Drug plan also covers related services and supplies needed to administer covered devices. At least one form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive Prescription Drugs by logging in to Navitus Member Portal at [member.portal.navitus.com](http://member.portal.navitus.com) or calling the Navitus Customer Care number at 844-268-9789.

We cover over-the-counter (OTC) and Generic Prescription Drugs and devices for each of the methods identified by the FDA at no cost share. If a Generic Prescription Drug or device is not available for a certain method, You may obtain certain Brand-Name Prescription Drug for that method at no cost share.

When prescribed female contraceptives, You will be dispensed up to a 12-month supply of the Prescription contraception at one time.

**Important note:**

You may qualify for a medical exception if Your Provider determines that the contraceptives covered standardly as preventive are not medically appropriate. Your Prescriber may request a medical exception and submit the exception to us.

**Diabetic Supplies**

Eligible Health Services include but are not limited to the following diabetic supplies upon Prescription by a Prescriber:

- Injection devices including insulin syringes, needles and pens;
- Test strips - blood glucose, ketone and urine;
- Blood glucose calibration liquid;
- Lancet devices and kits;
- Alcohol swabs;
- Continuous glucose monitors; and
- Insulin infusion disposable pumps.

See the *Diabetic Services and Supplies (including equipment and training)* section for medical Eligible Health Services.

**Immunizations**

Under the outpatient Prescription Drugs benefit, Eligible Health Services include preventive immunizations for infectious diseases as required by the federal Patient Protection and Affordable Care Act (PPACA) guidelines when administered at an In-Network Pharmacy.

You should contact:

Navitus Customer Care at 844-268-9789 to find a participating In-Network Pharmacy.

You should contact the Pharmacy for availability as not all Pharmacies will stock all available

vaccines.

Your medical plan also provides coverage for preventive immunizations as required by the federal Patient Protection and Affordable Care Act (PPACA) guidelines. For details, refer to the *Preventive Care and Wellness* section.

### **Infertility Drugs**

Eligible Health Services include oral and injectable Prescription Drugs used primarily for the purpose of treating the underlying cause of Infertility.

### **Orally Administered Anti-Cancer Drugs, Including Chemotherapy Drugs**

Eligible Health Services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

### **Preventive Care Drugs and Supplements**

Eligible Health Services include preventive care drugs and supplements (including over-the-counter drugs and supplements) as required by the *Patient Protection and Affordable Care Act* (PPACA) guidelines when prescribed by a Prescriber and the Prescription is submitted to the pharmacist for processing.

### **Risk-Reducing Breast Cancer Prescription Drugs**

Eligible Health Services include Prescription Drugs used to treat people who are at:

- Increased risk for breast cancer and
- Low risk for adverse medication side effects.

### **Tobacco Cessation Prescription and Over-the-Counter Drugs**

Eligible Health Services include FDA- approved Prescription Drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a Prescriber and the Prescription is submitted to the pharmacist for processing.

### **Outpatient Prescription Drugs Exclusions**

The following are not covered under the outpatient Prescription Drugs benefit:

- Abortion drugs;

- Allergy sera and extracts administered via injection;
- Any services related to the dispensing, injecting or application of a drug;
- Biological sera unless specified on the Navitus Marketplace Select Formulary;
- Compounded Prescriptions containing bulk chemicals not approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones;
- Cosmetic drugs including medications and preparations used for Cosmetic purposes;
- Devices, products and appliances, except those that are specially covered;
- Dietary supplements including medical foods;
- Drugs or medications:
  - Administered or entirely consumed at the time and place it is prescribed or provided;
  - Which do not, by federal or state law, require a Prescription order i.e. over-the-counter (OTC) drugs), even if a Prescription is written except as specifically provided above;
  - That are therapeutically equivalent or therapeutically alternative to a covered Prescription Drug (unless a medical exception is approved);
  - Not approved by the FDA or not proven safe or effective;
  - Provided under Your medical plan while an inpatient of a healthcare facility;
  - Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by Our Pharmacy and Therapeutics Committee;
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF);
  - For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration);
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ;
  - That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications; and
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic

short stature unless there is evidence that the covered person meets one or more clinical criteria detailed in Our Precertification and clinical policies;

- Duplicative drug therapy (e.g. two antihistamine drugs);
- Immunizations related to work;
- Immunization or immunological agents except as specifically stated in the Statement of Benefits or the certificate;
- Infertility:
  - Injectable Prescription Drugs used primarily for the treatment of Infertility;
- Injectables:
  - Any charges for the administration or injection of Prescription Drugs or injectable insulin and other Injectable Drugs covered by Us;
  - Needles and syringes, except for those used for insulin administration; and
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified Provider or licensed certified Health Professional in an outpatient setting. This exception does not apply to Depo Provera and other Injectable Drugs used for contraception;
- Off-label drug use except for indications recognized through peer-reviewed medical literature or if standard medical literature supports the use as both safe and effective. Both state and federal laws define what counts as standard medical literature;
- Prescription Drugs:
  - That are considered oral dental preparations and fluoride rinses , except pediatric fluoride tablets or drops as specified on the Navitus Marketplace Select Formulary; and
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card;
- Test agents except diabetic test agents;
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the Navitus Marketplace Select Formulary and
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on Our Navitus Marketplace Select Formulary.

## How You Get an Emergency Prescription Filled

You may not have access to an In-Network Pharmacy in an emergency or urgent care situation. If You must fill a Prescription in either situation, We will reimburse You as shown in the table below.

| Type of Pharmacy        | Your Cost Share                                                                                                                                                                                                                                                                                                                                                                           |
|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| In-network Pharmacy     | <ul style="list-style-type: none"><li>You pay the Copayment.</li></ul>                                                                                                                                                                                                                                                                                                                    |
| Out-of-Network Pharmacy | <ul style="list-style-type: none"><li>You pay the Pharmacy directly for the cost of the Prescription. Then You fill out and send a Prescription Drug refund form to us, including all itemized Pharmacy receipts.</li><li>Submission of a claim doesn't guarantee payment. If Your claim is approved, You will be reimbursed the cost of Your Prescription less Your Copayment.</li></ul> |

## Where Your Statement of Benefits Fits In

You are responsible for paying Your part of the cost sharing. The Statement of Benefits shows any benefit limitations and any out-of-pocket costs You are responsible for. Keep in mind that You are responsible for costs not covered under this plan.

Your outpatient Prescription Drug costs are based on:

- The type of Prescription Drug You are prescribed; and
- Where You fill Your Prescription.

The plan may, in certain circumstances, make some preferred Brand-Name Prescription Drug available to Covered Persons at the Generic Prescription Drug Copayment level.

## How Your Copayment Works

Your Copayment is the amount You pay for each Prescription fill or refill after You have paid Your Policy Year Deductible. Your Statement of Benefits shows You which Copayments You need to pay for specific Prescription fill or refill. You will pay any cost sharing directly to the In-Network Pharmacy.

Your Statement of Benefits shows the Out-of-Pocket Limits that apply to Your plan. Once You reach Maximum Out-of-Pocket Limit, Your plan will pay for outpatient Prescription Drug Covered Benefits for the remainder of that Policy Year.

## What Precertification Requirements Apply?

### Precertification

For certain drugs, you, Your Prescriber or Your pharmacist needs to get approval from Us before We will cover the drug. This is called "Precertification". The requirement for getting approval in advance guides appropriate use of Precertified drugs and makes sure they are Medically Necessary.

For the most up-to-date information, call Navitus Customer Care at 844-268-9789 or by logging in to Your Navitus Member Portal [memberportal.navitus.com](http://memberportal.navitus.com)

### **Step Therapy**

There is another type of Precertification for Prescription Drugs, and that is Step Therapy. Step Therapy is a type of Precertification where We require You to first try certain Prescription Drugs to treat Your medical condition before We will cover another Prescription Drug for that condition.

You will find the Step Therapy Prescription Drugs on the Navitus Marketplace Select Formulary. For the most up-to-date information, call Navitus Customer Care at 844-268-9789 or log into your Navitus member portal at [memberportal.navitus.com](http://memberportal.navitus.com).

### **Medical Exceptions**

Sometimes You or Your Provider may ask for a medical exception for Prescription Drugs that are not covered or for which coverage was denied. You, someone who represents You or Your Provider can contact us. You will need to provide Us with the required clinical documentation. Any exception granted is based upon an individual and is a case by case decision that will not apply to other Covered Persons.

For directions on how You can submit a request for a review:

- Contact Navitus Customer Care at 844-268-9789;
- Go online to the Navitus Member Portal at [memberportal.navitus.com](http://memberportal.navitus.com) ; or
- Submit the request in writing to Navitus Health Solutions, PO BOX 999, Appleton, WI 54912-0999.

You, someone who represents You or Your Provider may seek a quicker medical exception when the situation is urgent. It's an urgent situation when You have a health condition that may seriously affect Your life, health, or ability to get back maximum function. It can also be when You are going through a current course of treatment using a non-covered drug.

### **Prescribing Units**

Some outpatient Prescription Drugs are subject to quantity limits. These quantity limits help Your Prescriber and pharmacist check that Your outpatient Prescription Drug is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by Us to set these quantity limits.

Any outpatient Prescription Drug that has duration of action extending beyond one (1) month shall require the number of Copayments per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) Copayments.

## General Exclusions

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We already told You about the many health care services and supplies that are eligible for coverage under Your plan in the *Eligible Health Services and Exclusions* section. In that section We also told You that some health care services and supplies have exceptions and some are not covered at all (exclusions).

In this section We tell You about the general exclusions that apply to Your plan. And just a reminder, you'll find coverage limitations in the Statement of Benefits.

### General Exclusions

The following are not Eligible Health Services under Your plan except as described in:

- The *Eligible Health Services and Exclusions* section of this Certificate of Coverage; or
- A rider or amendment issued to You for use with this Certificate of Coverage.

#### Abortion

- Abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger.

#### Acupuncture

- Acupuncture; or Acupressure

#### Air or Space Travel

- Traveling in, on or descending from any aircraft, including a hang glider, while the aircraft is in flight. This includes descending by a parachute, wingsuit or any other similar device.

This exclusion does not apply if:

- You are traveling solely as a fare-paying passenger;
- You are traveling on a licensed, commercial, regularly scheduled non-military aircraft;
- You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
  - The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved;
  - You are as a passenger with no duties at all on an aircraft used only to carry passengers or You are a pilot or a part of the flight crew on an aircraft owned or leased by the Policyholder performing duties for the Policyholder; and

#### Alternative Health Care

- Services and supplies given by a Provider for alternative health care. This includes but is not limited to aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, hypnotherapy, and

traditional Chinese medicine.

### **Armed Forces**

- Services and supplies received from a Provider as a result of an Injury sustained, or Illness contracted, while in the service of the armed forces of any country. When You enter the armed forces of any country, We will refund any unearned pro-rata Premium to the Policyholder.

### **Beyond Legal Authority**

- Services and supplies provided by a Health Professional or other Provider that is acting beyond the scope of its legal authority.

### **Blood, Blood Plasma, Synthetic Blood, Blood Derivatives or Substitutes**

Examples of these are:

- The provision of blood to the Hospital, other than blood derived clotting factors;
- Any related services including processing, storage or replacement expenses;
- The services of blood donors, apheresis or plasmapheresis; and
- For autologous blood donations, only administration and processing expenses are covered.

### **Clinical Trial Therapies (Experimental or Investigational)**

- Your plan does not cover clinical trial therapies (Experimental or Investigational), except as described in the *Eligible Health Services and Exclusions - Clinical Trial Therapies – Experimental or Investigational* section

### **Cosmetic Services and Plastic Surgery**

- Any treatment, Surgery (Cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body.

This exclusion does not apply to:

- Surgery after an Accidental Injury when performed as soon as medically feasible (Injuries that occur during medical treatments are not considered Accidental Injuries even if unplanned or unexpected.); and

### **Court-Ordered Testing**

- Court-ordered testing or care unless Medically Necessary.

### **Custodial Care**

Services and supplies meant to help You with activities of daily living or other personal needs.

Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed;
- Administering oral medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;

- Care of a bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care except in connection with Hospice Care, adult (or child) day care, or convalescent care;
- Institutional care. This includes Room and Board for rest cures, adult day care and convalescent care;
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any other services that a person without medical or paramedical training could be trained to perform;
- Any service that can be performed by a person without any medical or paramedical training; and;
- For behavioral health (mental health treatment and Substance Related Disorders treatment):
  - Services provided when You have reached the greatest level of function expected with the current level of care, for a specific diagnosis;
  - Services given mainly to:
    - Maintain, not improve, a level of function;
    - Provide a place free from conditions that could make Your physical or mental state worse.

### **Dental Care for Adults**

- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of Injuries to or diseases of the teeth;
  - Dental services related to the gums;
  - Apicoectomy (dental root resection);
  - Orthodontics;
  - Root canal treatment;
  - Soft tissue impactions;
  - Alveolectomy;
  - Augmentation and vestibuloplasty treatment of periodontal disease;
  - False teeth;
  - Prosthetic restoration of dental implants; and
  - Dental implants.

This exception does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

### **Educational Services**

Examples of these services are:

- Any service or supply for education, training or retraining services or testing , except where described in the *Eligible Health Services and Exclusions – Diabetic Services and Supplies (including Equipment and Training)* section. This includes:
  - Special education;
  - Remedial education;
  - Job training; and
  - Job hardening programs; and
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

### **Examinations**

Any health or dental examinations needed:

- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract; or
- Because a law requires it:
  - To buy insurance or to get or keep a license;
  - To travel; or
  - To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

### **Experimental or Investigational**

- Experimental or Investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (Experimental or Investigational) or covered under clinical trials (routine patient costs). See the *Eligible Health Services and Exclusions – Other Services* section.

### **Facility Charges**

For care, services or supplies provided in:

- Rest homes;
- Assisted living facilities;
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care;
- Health resorts;
- Spas or sanitariums; and
- Infirmarys at schools, colleges, or camps.

### **Felony**

- Services and supplies that You receive as a result of an Injury due to Your commission of a felony

**Growth/Height Care**

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth; or
- Surgical Procedures, devices and growth hormones to stimulate growth.

**Hearing Aids**

Any tests, appliances and devices to:

- Improve Your hearing; or
- Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

**Incidental Surgeries**

- Charges made by a Physician for incidental Surgeries. These are non-medically necessary Surgeries performed during the same procedure as a Medically Necessary Surgery.

**Jaw Joint Disorder**

- Surgical treatment of Jaw Joint Disorders;
- Non-surgical treatment of Jaw Joint Disorders; and
- Jaw Joint Disorders treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to Jaw Joint Disorders including associated myofascial pain.

This exclusion does not apply to Covered Benefits for treatment of TMJ and CMJ as described in the *Eligible Health Services and Exclusions – Temporomandibular Joint Dysfunction (TMJ) and Craniomandibular Joint Dysfunction (CMJ) Treatment* section.

**Judgment or Settlement**

- Services and supplies for the treatment of an Injury or Illness to the extent that payment is made as a judgment or settlement by any person deemed responsible for the Injury or Illness (or their insurers).

**Mandatory No-Fault Laws**

- Treatment for an Injury to the extent benefits are payable under any state no-fault automobile coverage.

**Maintenance Care**

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. See the *Eligible Health Services and Exclusions – Habilitation Therapy Services* section.

**Medical Supplies – Outpatient Disposable**

- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths;
  - Bags;
  - Elastic garments;

- Support hose;
- Bandages;
- Bedpans;
- Syringes;
- Blood or urine testing supplies;
- Other home test kits;
- Splints;
- Neck braces;
- Compresses; and
- Other devices not intended for reuse by another patient.

**Medicare**

- Services and supplies available under Medicare, if You are entitled to premium-free

Medicare Part A or enrolled in Medicare Part B, or if You are not entitled to premium-free Medicare Part A or enrolled in Medicare Part B because You refused it, dropped it, or did not make a proper request for it.

**Care outside of the United States**

- Emergency Services and supplies received by a Covered Person in a country that has a socialized medicine program.
  - In Countries where there is no socialized medicine program, only emergency services will be covered.
- Non-emergent services will not be covered anywhere outside of United States

**Obesity Services**

- The treatment for obesity, including dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss. The only exceptions to this exclusion would be
  - if Surgery is determined to be Medically Necessary and Appropriate.
  - USPSTF A/B rated preventive obesity screenings and behavioral interventions.

**Other Primary Payer**

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer.

**Personal Care, Comfort or Convenience Items**

- Any service or supply primarily for Your convenience and personal comfort or that of a third party

**Private Duty Nursing**

- Services and supplies for nursing care provided by a R.N or L.P.N , except when provided elsewhere by this plan.

**Riot**

- Services and supplies that You receive from Providers as a result of an Injury from Your “participation in a riot”. This means when You take part in a riot in any way such as inciting,

or conspiring to incite, the riot. It does not include actions that You take in self-defense as long as they are not against people who are trying to restore law and order.

### **Routine Exams**

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Eligible Health Services and Exclusions* section.

### **Services Provided by a Family Member**

- Services provided by a spouse, domestic partner, civil union partner, parent, child, step-child, brother, sister, in-law or any household member.

### **Services, Supplies and Drugs Received Outside of the United States**

- Non-emergency services, outpatient Prescription Drugs or supplies received outside of the United States. They are not covered even if they are covered in the United States under this Certificate of Coverage.

### **Sexual Dysfunction and Enhancement**

- Any treatment, surgery, Prescription Drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, Prescription Drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; or unless it is a medically necessary reconstructive surgeries following trauma or disease like cancer; Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services; and

### **Stays in a Facility for Dementia or Amnesia**

- Stay in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment.

### **Strength and Performance**

- Services, devices and supplies such as drugs or preparations designed primarily for enhancing Your:
  - Strength;
  - Physical condition;
  - Endurance; and
  - Physical performance.

### **Telemedicine**

- Services given by Providers that are not contracted with Peak Health to provide Telemedicine services;
- Services given when You are not present at the same time as the Provider; and
- Services including:
  - Telephone calls;

- Telemedicine kiosks; and
- Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke).

### **Therapies and Tests**

- Full body CT scans;
- Hair analysis;
- Hypnosis and hypnotherapy;
- Massage therapy, except when used as a physical therapy modality; and
- Sensory or auditory integration therapy.

### **Transportation**

- Transportation, except as specifically provided in the *Emergency Services and Urgent Care* and *Other Services - Ambulance Services* sections.

### **Treatment in a Federal, State, or Governmental Entity**

- Any care in a Hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

### **Vision Care for Adults**

- Routine vision exam provided by an ophthalmologist or optometrist, including refraction and glaucoma testing; and
- Vision care services and supplies.

### **Voluntary Sterilization**

- Reversal of voluntary sterilization procedures, including related follow-up care.

### **Work, Recreational Activities or Vocation**

- Services provided in conjunction with work, recreational activities or vocation.

### **Work Related Illness or Injuries**

- Coverage available to You under worker's compensation or under a similar program under local, state or federal law for any Illness or Injury related to employment or self-employment; and
- A source of coverage or reimbursement will be considered available to You even if You waived Your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If You submit proof that You are not covered for a particular Illness or Injury under such law, then that Illness or Injury will be considered "non-occupational" regardless of cause.

## Who Provides the Care

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Just as the starting point for coverage under Your plan is whether the services and supplies are Eligible Health Services, the foundation for getting covered care is through Our network of Providers. This section tells You about in-network and Out-of-Network Providers.

In accordance with West Virginia requirements, We have a network access plan which helps ensures the providers in Our Network are available and accessible. This network access plan is available to You upon request and You can also find it on the Peak Health website at [peakhealth.org](https://peakhealth.org).

### In-Network Providers

We have contracted with Providers to provide Eligible Health Services to You. These Providers make up the network for Your plan. For You to receive the in-network level of benefits You must use In-Network Providers for Eligible Health Services. There are some exceptions:

- Emergency Services – refer to the description of Emergency Services and urgent care in the *Eligible Health Services and Exclusions* section;
- Urgent care – refer to the description of Emergency Services and urgent care in the *Eligible Health Services and Exclusions* section;
- Transplants – see the description of transplant services in the *Eligible Health Services and Exclusions – Specific Conditions* section;
- If a Network Provider not reasonably available – You can get Eligible Health Services under Your plan from Out-of-Network Providers if an appropriate In-Network Provider is not

reasonably available. You must request access to the Out-of-Network Provider in advance and We must agree. Contact Member Services at the toll-free number on Your ID card in the *How to Contact Us for Help* section for assistance.

You may select an In-Network Provider from the Directory through Your Peak Health website at [peakhealth.org](http://peakhealth.org). You can search Our online Directory for names and locations of Providers or contact Member Services at the toll-free number on Your ID card in the *How to Contact Us for Help* section.

You will not have to submit claims for treatment received from In-Network Providers. Your In-Network Provider will take care of that for You. And We will directly pay the In-Network Provider for what the plan owes.

### **Keeping a Provider You Go to Now - Continuity of Care**

You may have to find a new Provider when:

- You join the plan and the Provider You have now is not in the network; or
- You are already covered under another Peak Health plan and Your Provider stops being in Our network.

But in some cases, You may be able to keep going to Your current Provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

If this situation applies to you, contact Us for details. As long as the Provider did not leave the network based on fraud, lack of quality standards, or Our termination of the Provider, you'll be able to receive transitional care from Your Provider for a period up to 3 months from when We notified You of their network status or the end of Your treatment, whichever is sooner.

If You are pregnant and have entered Your second trimester, transitional care will be through the time required for postpartum care directly related to the delivery.

You will not be responsible for an amount that exceeds the cost share that would have applied had Your Provider remained in the network.

## **What the Plan Pays and What You Pay**

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Who pays for Your Eligible Health Services? This section gives the general rule and explains these key terms:

- Your Policy Year Deductible;
- Your Copayments;
- Your Coinsurance; and
- Your Maximum Out-of-Pocket Limit.

We also remind You that sometimes You will be responsible for paying the entire bill – for example, if You get care that is not an Eligible Health Service.

### **The General Rule**

When You receive Eligible Health Services you will be responsible to pay for the entire expense up to any Policy Year Deductible limit. When that Deductible limit has been reached, the plan and You share the expense up to any Maximum Out-of-Pocket Limit. The Statement of Benefits lists how much Your plan pays and how much You pay for each type of health care service.

After You reach Your Maximum Out-of-Pocket Limit, the plan will pay the entire expense. When We say “expense” in this general rule, We mean the Negotiated Charge for and an In-Network Provider, and Allowed Amount for an Out-of-Network Provider. See the *Definitions* section for what these terms mean.

See the Statement of Benefits for any exceptions to this general rule.

### **Important Exceptions – When Your Plan Pays All**

Under the in-network level of coverage, Your plan pays the entire expense for all Eligible Health Services under the *Preventive Care and Wellness* benefit.

### **Important Exceptions – When You Pay All**

You pay the entire expense for an Eligible Health Service:

- When You get a health care service or supply that is not Medically Necessary. See the *Medical Necessity, Referral and Precertification Requirements* section.
- When Your plan requires Precertification, Your Physician requested it, We refused it, and You get an Eligible Health Service without Precertification. See the *Medical Necessity, Referral and Precertification Requirements* section.

When you get a health care service or supply from an Out-of-Network Provider, except for situations described in the *Out-of-Network Coverage* section.

In all these cases, the Provider may require You to pay the entire charge. Any amount You pay will not count towards Your Policy Year Deductible or towards Your Maximum Out-of-Pocket Limit.

## **Important Exceptions – When You Go to the Emergency Room**

When You have to visit an emergency room for Emergency Services, the general rule described earlier doesn't apply.

Instead, You pay Your initial share, a Copayment, for each visit. The Copayment amount is shown in the Statement of Benefits. After the Copayment, if You haven't satisfied Your Policy Year Deductible, You pay any remaining expense for the visit, up to the amount of Your Policy Year Deductible.

Once the Policy Year Deductible has been satisfied, the plan and You share the remaining expense up to any Maximum Out-of-Pocket Limit. The Statement of Benefits lists what percentage of this remaining amount Your plan pays. Your share is called Coinsurance.

After You reach Your Maximum Out-of-Pocket Limit, the plan will pay any remaining expense.

As with the general rule, when We say "expense" We mean the Negotiated Charge for an In-Network Provider, and Allowed Amount for an Out-of-Network Provider.

## **Special Financial Responsibility**

You are responsible for the entire expense of any cancelled or missed appointments.

Neither You nor We are responsible for:

- Charges for which You have no legal obligation to pay;
- Charges that would not be made if You did not have coverage;
- Charges, expenses, or costs in excess of the Negotiated Charge for in-network Covered Benefits; and
- Standby charges made by a Physician.

## **Where Your Statement of Benefits Fits In**

### **How Your Policy Year Deductible Works**

Your Policy Year Deductible is the amount You need to pay for Eligible Health Services per Policy Year before Your plan begins to pay for Eligible Health Services. Your Statement of Benefits shows the Policy Year Deductible amounts for Your plan.

### **How Your Copayment Works**

Your Copayment is the amount You pay for Eligible Health Services after You have paid Your Policy Year Deductible. Your Statement of Benefits shows You which Copayments You need to pay for specific Eligible Health Services.

### **How Your Maximum Out-of-Pocket Limit Works**

You will pay Your Policy Year Deductible, Copayments, and Coinsurance up to the Maximum Out-of-Pocket Limit for Your plan. Your Statement of Benefits shows the Maximum Out-of-Pocket Limits that apply to Your plan. Once You reach Your Maximum Out-of-Pocket Limit, Your plan will pay for Covered Benefits for the remainder of that Policy Year.

**Important note:**

See the Schedule of Benefits for any Policy Year Deductibles, Copayments, Coinsurance, Maximum Out-of-Pocket Limit and maximum age, visits, days, hours, admissions that may apply.

## Claim Decisions and Appeals Procedures

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In the previous section, We explained how You and We share responsibility for paying for Your Eligible Health Services.

When a claim comes in, We decide and tell You how You and We will split the expense. We also explain what You can do if You think We got it wrong.

### Claim Procedures

For claims involving Out-of-Network Providers:

| Notice                | Requirement                                                                                                                                                                                                                                      | Deadline                                                                                                                                                                                                                                                                        |
|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Submit a claim        | <ul style="list-style-type: none"><li>You should notify and request a claim form from the us.</li><li>The claim form will provide instructions on how to complete and where to send the form(s).</li></ul>                                       | <ul style="list-style-type: none"><li>If You are unable to complete a claim form, You may send us:<ul style="list-style-type: none"><li>A description of services</li><li>Bill of charges</li><li>Any medical documentation You received from Your Provider</li></ul></li></ul> |
| Proof of loss (claim) | <ul style="list-style-type: none"><li>A completed claim form and any additional information required by us.</li></ul>                                                                                                                            | <ul style="list-style-type: none"><li>You or Your Provider must send Us notice and proof within 365 days of the date You received services, unless You are legally unable to notify us.</li></ul>                                                                               |
| Benefit payment       | <ul style="list-style-type: none"><li>Written proof must be provided for all benefits.</li><li>If We challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss.</li></ul> | <ul style="list-style-type: none"><li>Benefits will be paid as soon as the necessary proof to support the claim is received.</li></ul>                                                                                                                                          |

### Types of Claims and Communicating Our Claim Decisions

You or Your Provider is required to send Us a claim in writing. You can request a claim form from Us. We will review that claim for payment to the Provider or to You as appropriate.

There are different types of claims. The amount of time that We have to tell You about Our decision on a claim depends on the type of claim. The section below will tell You about the different types of claims.

**Urgent Care Claim**

An urgent claim is one for which the Physician treating You decides that a delay in getting medical care, could put Your life or health at risk. Or a delay might put Your ability to regain maximum function at risk.

It could also be a situation in which You need care to avoid severe pain.

If You are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of Your unborn baby.

**Pre-Service Claim**

A pre-service claim is a claim that involves services You have not yet received and which We will pay for only if We Precertify them.

**Post-Service Claim**

A post service claim is a claim that involves health care services You have already received.

**Concurrent Care Claim Extension**

A concurrent care claim extension occurs when You ask Us to approve more services than We already have approved. Examples are extending a Hospital Stay or adding a number of visits to a Provider.

**Concurrent Care Claim Reduction or Termination**

A concurrent care claim reduction or termination occurs when We decide to reduce or stop payment for an already approved course of treatment. We will notify You of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until You receive a final appeal decision from Us or an external review organization if the situation is eligible for external review.

During this continuation period, You are still responsible for Your share of the costs, such as Copayments, Coinsurance and Deductibles that apply to the service or supply. If We uphold Our decision at the final internal appeal, You will be responsible for all of the expenses for the service or supply received during the continuation period.

**Claim Review Timelines**

The chart below shows a timetable view of the different types of claims and how much time We have to tell You about Our decision.

We may need to tell Your Physician about Our decision on some types of claims, such as a concurrent care claim, or a claim when You are already receiving the health care services or are in the Hospital.

| <b>Type of Request</b> | <b>Time Frame</b>                                                             |
|------------------------|-------------------------------------------------------------------------------|
| Concurrent Care Claim* | 24 hours for urgent request<br><br>15 calendar days<br>for non-urgent request |
| Urgent Care Claim**    | Within 72 hours                                                               |
| Pre-Service Claim***   | 5 business days                                                               |
| Post-Service Claim**** | 30 days                                                                       |

\* Any request to extend the course of Treatment beyond the period of time or number of Treatments that is a Claim involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies, and we shall notify you of the benefit determination, whether adverse or not, within 24 hours after receipt of the Claim provided that any such Claim is made to us at least 24 hours prior to the expiration of the prescribed period of time or number of Treatments.

\*\* If we have not been provided with sufficient information to determine if the benefits are covered or payable, we will notify you and as soon as possible, but not later than 24 hours after receipt of the Claim of the specific information necessary to complete the Claim. You and shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours to provide the specified information.

\*\*\* If your Pre-Service Claim is improperly filed, you will be notified within 2 business days of receipt of your Claim. If additional information is needed to perfect or process the Claim, we will provide you with at least 3 business days from receipt of the notice to provide the specified information.

\*\*\*\* If additional information is needed, we will notify you within 30 days of receipt of the Claim and will provide you with at least 45 days from receipt of the notice to provide the specified information. The 30 day period may also be extended one time by us, for up to 15 days, if we determine that such an extension is necessary due to matters beyond our control

and notify you, prior to the expiration of the initial 30 day period, of the circumstances requiring the extension of time

## **Adverse Benefit Determinations**

We pay many claims at the full rate Negotiated Charge with In-Network Provider and the Allowed Amount with an Out-of-Network Provider, except for Your share of the costs. But sometimes We pay only some of the claim. And sometimes We deny payment entirely. Any time We deny even part of the claim that is an “adverse benefit determination” or “adverse decision”. It is also an “adverse benefit determination” if We rescind Your coverage entirely. Coverage can only be rescinded due to fraud.

If We make an adverse benefit determination, We will tell You in writing. If you have questions regarding an adverse benefit determination, You can call Member Services at the toll-free number listed on Your ID card in the *How to Contact Us for Help* section or write Member Services.

## **The Difference Between a Complaint and an Appeal**

### **A Complaint**

You may not be happy about a Provider or an operational issue, and You may want to complain. You can call Member Services at the toll-free number on Your ID card in the *How to Contact Us for Help* section or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that You think are important. We will send you a letter letting you know we have received your complaint within 3 working days. We will then review the information and provide You with a written response within 20 working days of receiving the complaint. If we need to, we can extend this timeframe up to an additional 10 working days We will let You know if We need more time or information to make a decision.

### **An Appeal**

You can ask Us to re-review an adverse benefit determination. This is called an appeal. You can appeal to Us by calling Member Services at the toll-free number on Your ID card in the *How to Contact Us for Help* section.

## **Appeals of Adverse Benefit Determinations**

You can appeal Our adverse benefit determination. We will assign Your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time You receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination or by calling Member Services at the toll-free number on Your ID card in the *How to Contact Us for Help* section. For a written appeal, You need to include:

- Your name;
- The Policyholder’s name;
- A copy of the adverse benefit determination;

- Your reasons for making the appeal; and
- Any additional information You would like the reviewer to consider.

Another person may submit an appeal for you, including a Provider. That person is called an authorized representative. You need to tell Us if You choose to have someone else appeal for You (even if it is Your Provider). You should fill out an authorized representative form telling Us that You are allowing someone to appeal for You. You can get this form on Our website or by calling Member Services at the toll-free number on Your ID card in the *How to Contact Us for Help* section. The form will tell You where to send it to us. You can use an authorized representative at any level of appeal.

You can appeal one time under this plan.

You can request a copy of the information used in the decision-making process at any time free of charge.

### **Urgent Care or Pre-Service Claim Appeals**

To make sure we process your Urgent pre-service request without delay Peak will allow Your Healthcare Provider to appeal for You without having to fill out an authorized representative form.

We will provide You with any new or additional information that We used or that was developed by Us to review Your claim. We will provide this information at no cost to You before We give You a decision at Your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before We tell You what Our final decision is.

### **Timeframes for Deciding Appeals**

The amount of time that We have to tell You about Our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time We have to tell You about Our decision.

| <b>Type of notice</b>                     | <b>Urgent Care Claim</b> | <b>Pre-Service Claim</b> | <b>Post-Service Claim</b> | <b>Concurrent Care Claim</b>    |
|-------------------------------------------|--------------------------|--------------------------|---------------------------|---------------------------------|
| Acknowledgment of receipt or appeal       | Not applicable           | 3 working days           | 3 working days            | 3 working days                  |
| Appeal determinations for each Claim type | 72 hours                 | 30 days                  | 60 days                   | As appropriate to type of claim |

You may contact the West Virginia Department of Insurance for assistance regarding any complaint, grievance or appeal at the following address:

West Virginia Offices of the Insurance Commissioner

ATTN: Consumer Services Division  
P.O. Box 50540  
Charleston, WV 25305-0540  
phone: 304-558-3386  
fax: 304-558-4965

## **Exhaustion of the Appeals Process**

In most situations You must complete the appeal process with Us before You can take these other actions:

- Appeal through an external review process; or
- Pursue arbitration, litigation or other type of administrative proceeding.

You do not have to complete the appeals process before You may take other actions. These situations are:

- Contact the West Virginia Department of Insurance to request an investigation of a complaint or appeal;
- File a complaint or appeal with the West Virginia Department of Insurance;
- You have an urgent claim or a claim that involves ongoing treatment. You can have Your claim reviewed internally and at the same time through the external review process; or
- We did not follow all of the claim determination and appeal requirements of the West Virginia. But You will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm You;
  - The violation was for a good cause or beyond Our control; or
  - The violation was part of an ongoing, good faith exchange between You and Us.

## **External Review**

External review is a review done by people in an organization outside of Peak Health. This is called an external review organization (ERO).

You have a right to external review only if:

- Our claim decision involved medical judgment;
- We decided the service or supply is
  - not Medically Necessary or not appropriate; or
  - Experimental or Investigational; and
- You have received an adverse determination.

You may also request external review if You want to know if the federal surprise bill law applies to Your situation.

If Our claim decision is one for which You can seek external review, We will say that in the notice of adverse benefit determination or final adverse benefit determination We send You. That notice also will describe the external review process. It will include a copy of the Request

for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To West Virginia Offices of the Insurance Commissioner;
- Within 120 days of the date You received the decision from Us; and
- You must include a copy of the notice from Us and all other important information that supports Your request.

You will pay for any information that You send and want reviewed by the ERO. We will pay for information We send to the ERO plus the cost of the review.

The West Virginia Offices of the Insurance Commissioner will:

- Contact the ERO that will conduct the review of Your claim; and
- The ERO will:
  - Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review;
  - Consider appropriate credible information that You sent;
  - Follow Our contractual documents and Your plan of benefits;
  - Send notification of the decision within 45 calendar days of the date We receive Your request form and all the necessary information.

We will stand by the decision that the ERO makes, unless We can show conflict of interest, bias or fraud.

#### **How Long Will It Take to Get an ERO Decision?**

The ERO decision will be made not more than 45 calendar days after We receive Your Notice of External Review Form with all the information You need to send in.

However, sometimes You can get a faster external review decision. Your Provider must call Us or send Us a Request for External Review Form.

There are two scenarios when You may be able to get an expedited external review:

#### **Expedited Review For Initial Adverse Determinations**

Your Provider tells Us that a delay in Your receiving health care services would:

- Jeopardize Your life, health or ability to regain maximum function; or
- Be much less effective if not started right away (in the case of Experimental or Investigational treatment).

#### **Expedited Review For Final Adverse Determinations**

Your Provider tells Us that a delay in Your receiving health care services would:

- Jeopardize Your life, health or ability to regain maximum function;

- Be much less effective if not started right away (in the case of Experimental or Investigational treatment); or
- The final adverse determination concerns an admission, availability of care, continued Stay or health care service for which You received Emergency Services, but have not been discharged from a facility.

If Your situation qualifies for this expedited review, You will receive a decision within 72 hours of Us getting Your request.

### **Recordkeeping**

We will keep the records of all complaints and appeals for at least 10 years.

### **Fees and Expenses**

We do not pay any fees or expenses incurred by You in pursuing a complaint or appeal.

## **Coordination of Benefits (COB)**

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Some people have health coverage under more than one health plan. If You do, We will work together with Your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

### **Key Terms**

Here are some key terms We use in this section. These terms will help You understand this COB section.

**Allowable Expense** - a health care expense that any of Your health plans cover to any degree. If the health care service is not covered by any of the plans, it is not an allowable expense. For example, Cosmetic Surgery generally is not an allowable expense under this plan.

**Other Plans** - In this section when We talk about “other plans” through which You may have other coverage for health care expenses, We mean:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors;
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;
- An automobile insurance policy;
- Governmental benefits; or
- Any contract that You can obtain or maintain only because of membership in or connection with a particular organization or group.

Different rules apply if You have Medicare. See the *How COB Works with Medicare* section below for those rules.

### **How COB Works**

- When this is the primary plan, We will pay Your medical claims first as if the other plan does not exist;
- When this is the secondary plan, We will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid; and
- We will never pay an amount that, together with payments from Your other coverage, add up to more than 100% of the allowable submitted expenses.

### **Determining Who Pays**

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.

| <b>If You are:</b>                                     | <b>Primary plan</b>                     | <b>Secondary plan</b>                 |
|--------------------------------------------------------|-----------------------------------------|---------------------------------------|
| Covered under this plan as a Policyholder or dependent | The plan covering You as a Policyholder | The plan covering You as a dependent. |

| <b>COB rules for dependent children</b>                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| Child of: <ul style="list-style-type: none"> <li>Parents who are married or living together</li> </ul>                                                                                                | The “birthday rule” applies. The plan of the parent whose birthday* (month and day only) falls earlier in the Calendar Year.<br><br>*Same birthdays--the plan that has covered a parent longer is primary                                                                                                                                                  | The plan of the parent born later in the year (month and day only)*.<br><br>*Same birthdays--the plan that has covered a parent longer is primary |
| Child of: <ul style="list-style-type: none"> <li>Parents separated or divorced or not living together and there is a court-order</li> </ul>                                                           | The plan of the parent whom the court said is responsible for health coverage.<br><br>But if that parent has no coverage then their spouse’s plan is primary.                                                                                                                                                                                              | The plan of the other parent.<br><br>But if that parent has no coverage, then their spouse’s plan is primary.                                     |
| Child of: <ul style="list-style-type: none"> <li>Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody</li> </ul> | Primary and secondary coverage is based on the birthday rule.                                                                                                                                                                                                                                                                                              |                                                                                                                                                   |
| Child of: <ul style="list-style-type: none"> <li>Parents separated or divorced or not living together and there is no court-order</li> </ul>                                                          | The order of benefit payments is: <ul style="list-style-type: none"> <li>The plan of the custodial parent pays first;</li> <li>The plan of the spouse of the custodial parent (if any) pays second;</li> <li>The plan of the noncustodial parents pays next; and</li> <li>The plan of the spouse of the noncustodial parent (if any) pays last.</li> </ul> |                                                                                                                                                   |
| <ul style="list-style-type: none"> <li>Child covered by: Individual who is not a parent (i.e. stepparent or grandparent)</li> </ul>                                                                   | Treat the person the same as a parent when making the order of benefits determination: Therefore See <i>Child of</i> content above.                                                                                                                                                                                                                        |                                                                                                                                                   |
| Longer or shorter length of coverage                                                                                                                                                                  | If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.                                                                                                                                                                                                                                         |                                                                                                                                                   |

|                          |                                                                     |
|--------------------------|---------------------------------------------------------------------|
| Other rules do not apply | If none of the above rules apply, the plans share expenses equally. |
|--------------------------|---------------------------------------------------------------------|

| How are Benefits Paid?                                                                    |                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Primary plan                                                                              | The primary plan pays Your claims as if there is no other health plan involved.                                                                                                                                                                                                                                                     |
| Secondary plan                                                                            | <p>The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that was not covered by the primary plan.</p> <p>The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.</p> |
| Benefit reserve<br>each family member has a separate benefit reserve for each Policy Year | <p>The benefit reserve is:</p> <ul style="list-style-type: none"> <li>• made up of the amount that the secondary plan saved due to COB and</li> <li>• used to cover any unpaid allowable expenses.</li> </ul> <p>Balance is erased at the end of each Policy Year</p>                                                               |

## How COB Works with Medicare

This section explains how the benefits under this plan interact with benefits available under Medicare. Keep in mind, if You have Medicare You are not eligible to enroll in this plan. But You might get Medicare after You are already enrolled in this plan, so these rules will apply.

You have Medicare when You are entitled to premium-free Medicare Part A or enrolled in Medicare Part B or Premium Part A, or both, by reason of:

- Age;
- Disability;
- ALS / Lou Gehrig's disease; or
- End stage renal disease.

**You also have Medicare if you are entitled to premium-free Medicare Part A but have declined or failed to enroll in Medicare Part A.** A person who is eligible only for Premium Medicare Part A and who has not enrolled in Medicare is not considered to have Medicare solely because they are eligible to purchase such coverage.

When You have Medicare, the Plan coordinates the benefits it pays with the benefits Medicare pays. If You are entitled to premium-free Medicare Part A but decline or fail to enroll, the Plan may calculate benefits as though Medicare had paid the amount it would have paid if You had enrolled, as permitted by applicable law. **The Plan will not coordinate benefits with Medicare as a primary payer solely because You were eligible to enroll in Premium Medicare Part A or Part B but chose not to enroll.**

| <b>How are Benefits Paid?</b>                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                   |                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|
| <b>If You have Medicare because of:</b>                                                                                                                           | <b>Primary plan</b>                                                                                                                                                                                                                                                                                                                                               | <b>Secondary plan</b> |
| Age                                                                                                                                                               | Medicare                                                                                                                                                                                                                                                                                                                                                          | This plan             |
| Disability                                                                                                                                                        | Medicare                                                                                                                                                                                                                                                                                                                                                          | This plan             |
| ALS / Lou Gehrig's disease                                                                                                                                        | Medicare                                                                                                                                                                                                                                                                                                                                                          | This plan             |
| End stage renal disease (ESRD)*                                                                                                                                   | This plan will pay first for the first 3 months unless You take a self-dialysis course, there is no Medicare waiting period and Medicare becomes primary payer on the first month of dialysis. Also, if a transplant takes place within the 3-month waiting period, Medicare becomes primary payer on the first of the month in which the transplant takes place. | Medicare              |
| *Note regarding ESRD: If You have Medicare due to age and then later have it due to ESRD, Medicare will remain Your primary Plan and this plan will be secondary. |                                                                                                                                                                                                                                                                                                                                                                   |                       |

This plan is secondary to Medicare in all other circumstances.

| How are Benefits Paid? |                                                                                                                                                                                                                                                                                    |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| We are primary         | We pay Your claims as if there is no Medicare coverage.                                                                                                                                                                                                                            |
| Medicare is primary    | We calculate the amount We would pay if there were no Medicare coverage. If the Medicare payment is equal to or more than what We would pay, We make no payment. If Medicare paid less than what We would pay, We pay the difference between Our payment and the Medicare payment. |

Charges that satisfy Your Part B deductible will be applied in the order received.

### Other Health Coverage Updates – Contact Information

You should contact Us if You have any changes to Your other coverage. We want to be sure Our records are accurate so Your claims are processed correctly:

- **Online:** Log in to Your Peak Health member website at [Mypeak.peakhealth.org](http://Mypeak.peakhealth.org). Select Find a Form, then select Your Other Health Plans or
- **By phone:** Call Member Services at the toll-free number on Your ID card in the *How to Contact Us for Help* section.

### Right to Receive and Release Needed Information

We have the right to release or obtain any information We need for COB purposes. That includes information We need to recover any payments from Your other health plans.

### Right to Pay Another Carrier

Sometimes another plan pays something We would have paid under Your plan. When that happens, We will pay Your plan benefit to the other plan.

### Right of Recovery

If We pay more than We should have under the COB rules, We may recover the excess from:

- Any person We paid or for whom We paid; or
- Any other plan that is responsible under these COB rules.

## **When Coverage Ends**

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Coverage can end for a number of reasons. This section tells You how and why coverage ends and when You may still be able to continue coverage.

### **When Will Your Coverage End?**

Your coverage under this plan will end on the date of the first event to occur:

- A Covered Person stops being an Eligible Dependent,;
- A Covered Person stops being an eligible Policyholder, all coverage stops at the end of the month in which the Policyholder became ineligible;
- The Policyholder does not pay the required contribution, all coverage stops at the end of the period for which payment was made;
- We have the right to void the coverage of any Covered Person who engages in fraudulent conduct, deception or misrepresentation relating to a Claim, Application for coverage, obtaining benefits or the use of an ID Card; or
- You have similar coverage under any group or non-group health benefits plan, or are provided similar benefits pursuant to, or in accordance with, the requirements of any state or federal law.

For individuals who are enrolled in a QHP through an Exchange, coverage may terminate when:

- The enrollee is no longer eligible for coverage through the Exchange;
- The enrollee changes from one QHP to another during the Annual Enrollment Period;
- The QHP terminates or is no longer certified; or
- Non-payment of premiums. If premiums are delinquent for an enrollee who receives Advance Premium Tax Credit, and at least one month's premium has been paid in full during the benefit year, coverage will be terminated after the exhaustion of a three (3) month grace period. Benefits will only be provided under this Policy for Covered Services received during the first month of the three (3) month grace period if payment of the appropriate premium amount by the Covered Person is not received prior to the end of the grace period. Failure of the Plan to receive Advance Payment of Premium Tax Credits shall not be grounds for termination of this Policy.

### **What Happens to Your Dependent Coverage if You Die?**

Unless coverage under this Policy is provided pursuant to enrollment through the Exchange, coverage may continue under this Policy for the covered Dependents upon termination of the Policyholder's coverage under this Policy due to the death of the Policyholder, for any period for which premium has already been paid. The Policyholder's spouse or Domestic Partner, if covered under this Policy shall thereafter become the Policyholder upon notice to the Plan of the termination of the Policyholder's coverage or the Policyholder's death. If the Policyholder's spouse or Domestic Partner was not covered under this Policy, a Dependent child may become a Policyholder but only under his or her own Policy.

### **What Happens to Your Dependent Coverage if You Enroll in Medicare?**

Unless coverage under this Policy is provided pursuant to enrollment through the Exchange, coverage may continue under this Policy for the covered Dependents upon termination of the Policyholder's coverage under this Policy due to enrollment in a Medicare Supplemental or Medicare Advantage plan for any period for which premium has already been paid. The Policyholder's spouse or Domestic Partner, if covered under this Policy shall thereafter become the Policyholder upon notice to the Plan of the termination of the Policyholder's coverage. If the Policyholder's spouse or Domestic Partner was not covered under this Policy, a Dependent child may become a Policyholder but only under his or her own Policy.



## **General Provisions**

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### **Entire Policy**

The Policy consists of several documents taken together. These documents are:

- The Policyholder's application;
- Your enrollment form, if the Policyholder requires one;
- The Policy;
- This Certificate(s) of Coverage;
- The Statement of Benefits; and
- Any riders, endorsement, inserts, attachments, and amendments to the Policy, the Certificate of Coverage, and the Statement of Benefits.

### **Compliance with Law**

This Certificate of Coverage was prepared in accordance with federal laws and state laws. You and We will interpret it according to these laws. Also, You are bound by Our interpretation of this Certificate of Coverage when We administer Your coverage, so long as We use reasonable authority.

We will apply the policies and procedures we have developed to help administer this plan.

### **Our Employees and Agents**

We are responsible to You for what Our employees and authorized agents do.

We are not responsible to You for what is done by others, such as Providers. They are not Our employees or agents. Providers in Our network are what the law calls Our independent contractors. That simply means We have a business relationship with them and they are not Our employees or agents.

### **Changes to Your Coverage**

Your coverage is defined by the Policy. This document may have amendments or riders too. Under certain circumstances, We or the law may change Your plan according to requirements of the Policy. When an emergency or epidemic is declared, We may modify or waive Precertification, Prescription quantity limits or Your cost share if You are affected. Only Peak Health may waive a requirement of Your plan. No other person – including the Provider – can do this.

### **Legal Action**

You must complete the appeal process before You take any legal action against Us for any expense or bill. See the *Claim Decisions and Appeals Procedures* section. You cannot take any action until 60 days after We receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

## **Physical Examinations and Evaluations**

At Our expense, We have the right to have a Physician of Our choice examine You. This will be done at all reasonable times while certification or a claim for benefits is pending or under review.

## **Records of Expenses**

You should keep complete records of Your expenses. They may be needed for a claim.

Things that would be important to keep are:

- Names of Physicians, Dental Providers and others who furnish services;
- Dates expenses are incurred; and
- Copies of all bills and receipts.

## **Honest Mistakes and Intentional Deception**

### **Honest Mistakes**

You or the Policyholder may make an honest mistake when You share facts with us. When We learn of the mistake, We may make a fair change in Premium contribution or in Your coverage. If We do, We will tell You what the mistake was. We won't make a change if the mistake happened more than 2 years before We learned of it.

### **Intentional Deception**

If We learn that You defrauded Us or You intentionally misrepresented material facts, We can take actions that can have serious consequences for Your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. This is called rescission;
- Loss of coverage going forward;
- Denial of benefits; and
- Recovery of amounts We already paid.

We also may report fraud to criminal authorities.

Rescission means You lose coverage both going forward and going backward. If We paid claims for Your past coverage, We will want the money back.

You have special rights if We rescind Your coverage as follows:

- We will give You 30 days advanced written notice of any rescission of coverage;
- You have the right to a Peak Health appeal; and
- You have the right to a third-party review conducted by an independent external review organization.

## **Assignment of Benefits**

When You see an In-Network Provider they will usually bill Us directly. When You see an Out-of-Network Provider, We may choose to pay You or to pay the Provider directly. Unless We

have agreed to do so in writing and to the extent allowed by law, We will not accept an assignment to an Out-of-Network Provider under this Policy. This may include:

- The benefits due;
- The right to receive payments; or
- Any claim You make for damages resulting from a breach, or alleged breach, of the terms of this Policy.

To request assignment You must complete an assignment form. The completed form must be sent to Us for consent.

\* Exception: We will be required to pay non-participating ground ambulance services directly, considering this payment as full for the service except for your usual copayments, coinsurance, and deductibles. Importantly, you will not be billed for any additional amount beyond their standard cost-sharing.

## **Recovery of Overpayments**

We sometimes pay too much for Eligible Health Services or pay for something that this plan doesn't cover. If We do, We can require the person We paid – You or Your Provider – to return what We paid. If We don't do that, We have the right to reduce any future benefit payments by the amount We paid by mistake.

## **Subrogation**

If someone else caused You to need care – say, a careless driver who injured You in a car crash – You may have a right to get money. We are entitled to that money, up to the amount We pay for Your care. We have that right no matter who the money comes from – for example, the other driver, the Policyholder or another insurance company.

To help Us get paid back:

- You are agreeing to repay Us from money You receive because of Your Injury;
- You are giving Us a right to seek money in Your name, from any person who causes You Injury and from Your own insurance. We can seek money only up to the amount We paid for Your care;
- You are agreeing to cooperate with Us so We can get paid back in full. For example, you'll tell us within 30 days of when You seek money for Your Injury or Illness. You'll hold any money you receive until We are paid in full. And you'll give Us the right to money You get, ahead of everyone else; and
- You are agreeing to provide Us notice of any money You will be receiving before pay out, or within 5 days of when You receive the money.

We don't have to reduce the amount we're due for any reason, even to help pay Your lawyer or pay other costs You incurred to get a recovery.

## **Your Health Information**

We will protect Your health information. We will only use or share it with others as needed for Your

care and treatment. We will also use and share it to help Us process Your Providers' claims and manage Your plan.

You can get a free copy of Our Notice of Privacy Practices. Just call Member Services at the toll-free number on Your ID card in the *How to Contact Us for Help* section.

When You accept coverage under this plan, You agree to let Your Providers share information with us. We need information about Your physical and mental condition and care.

## Definitions

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**Accident or Accidental** – An Injury to You that is not planned or anticipated. An Illness does not cause or contribute to an Accident.

**Actual Charge** – The standard office charge established by a Provider for services and supplies that are Covered Benefits under the plan and that the Provider gives to You.

**Allowed Amount**- The Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of:

- The amount negotiated with Network Providers for the Emergency service furnished;
- The amount for the Emergency Service calculated using the same method we use to determine payments for Non-Network services but substituting the Network cost-sharing provisions for the Non-Network cost-sharing provisions; or
- The amount that would be paid under Medicare for the Emergency Service

**Ambulance** – A vehicle staffed by medical personnel and equipped to transport an Ill or Injured person.

**Behavioral Health Provider** – An individual professional that is licensed or certified to provide diagnostic and/or therapeutic services for Mental Health Disorders and Substance Related Disorders under the laws of the jurisdiction where the individual practices.

**Benefit Year**- The calendar year for which you have coverage under the Plan

**Benefit Year Deductible** – The amount You pay for Eligible Health Services per Benefit Year before Your plan starts to pay as listed in the Statement of Benefits.

**Billed Amount** – The amount billed by a Provider's office for the services and supplies that are Covered Benefits under the plan and the Provider gives to You.

**Biosimilar Prescription Drug** – A biological Prescription Drug that is highly similar to a U.S. Food and Drug Administration (FDA) – licensed reference biological Prescription Drug notwithstanding minor differences in clinically inactive components, and for which there are no clinically meaningful differences between the highly similar biological Prescription Drug and the reference biological Prescription Drug in terms of the safety, purity, and potency of the drug. As defined in accordance with U.S. Food and Drug Administration (FDA) regulations.

**Body Mass Index** – This is a degree of obesity and is calculated by dividing Your weight in kilograms by Your height in meters squared.

**Brand-Name Prescription Drug** – An FDA-approved Prescription Drug marketed with a specific name or trademark name by the company that manufactures it, usually by the company which develops and patents it.

**Calendar Year** – A period of 12 months beginning January 1<sup>st</sup> and ending on December 31<sup>st</sup>.

**Coinsurance** – Coinsurance is both the percentage of Eligible Health Services that the plan pays and what You pay. The specific percentage that We have to pay for Eligible Health Services is listed in the Statement of Benefits.

**Copayments** – The specific dollar amount You have to pay for a health care service listed in the Statement of Benefits.

**Cosmetic** – Services, drugs or supplies that are primarily intended to alter, improve or enhance Your appearance.

**Covered Benefits** – Eligible Health Services that meet the requirements for coverage under the terms of this plan, including:

- They are Medically Necessary; and
- You received Precertification and/or a Referral form, if required.

**Covered Dependent** – A person who is insured under the Policy as a dependent of a Covered Policyholder.

**Covered Person** – A Policyholder or a Covered Dependent of a Policyholder for whom all of the following applies:

- The person is eligible for coverage as defined in the Certificate of Coverage;
- The person has enrolled for coverage and paid any required Premium contribution; and
- The person's coverage has not ended.

**Craniomandibular Joint Dysfunction (CMJ)** – This is a disorder of the jaw joint.

**Custodial Care** – Services and supplies mainly intended to help meet Your activities of daily living or other personal needs. Care may be Custodial Care even if it prescribed by a Physician or given by trained medical personnel.

**Dental Emergency** – Any dental condition that:

- Occurs unexpectedly;
- Requires immediate diagnosis and treatment in order to stabilize the condition; and
- Is characterized by symptoms such as severe pain and bleeding.

**Dental Emergency Services** – Services and supplies given by a Dental Provider to treat a Dental Emergency.

**Dental Provider** – Any individual legally qualified to provide dental services or supplies. This may be any of the following:

- Any Dentist;
- Group;

- Organization;
- Dental facility; or
- Other institution or person.

**Dentist** – A legally qualified Dentist licensed to do the dental work he or she performs.

**Detoxification** – The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs.

This can be done by metabolic or other means as determined by a Physician or a nurse practitioner working within the scope of their licenses. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

**Directory** – The list of In-Network Providers for Your plan. The most up-to-date Directory for Your plan appears at [peakhealth.org](http://peakhealth.org). When searching from Our online Provider Directory, You need to make sure that You are searching for Providers that participate in Your specific plan. In-Network Providers may only be considered for certain Peak Health plans. When searching for In-Network Dental Providers, You need to make sure You are searching under Pediatric Dental plan.

**Durable Medical Equipment (DME)** – Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Mainly used in the treatment of an Illness or Injury;
- Suited for use in the home;
- Not normally used by people who do not have an Illness or Injury;
- Not for altering air quality or temperature; and
- Not for exercise or training.

**Effective Date of Coverage** – The date Your and Your dependent's coverage begins under this Certificate of Coverage as noted in Peak Health's records.

**Eligible Health Services** – The health care services and supplies and outpatient Prescription Drugs listed in the *Eligible Health Services and Exclusions* section and not carved out or limited in the *General Exclusions* section of this Certificate of Coverage or in the Statement of Benefits.

**Emergency Admission** – An admission to a Hospital or treatment facility ordered by a Physician within 24 hours after You receive Emergency Services.

**Emergency Medical Condition** – An acute, severe medical condition that would lead a prudent layperson to reasonably believe that the condition, Illness, or Injury is of a severe nature. And that if

You don't get immediate medical care it could result in:

- Placing Your health in serious danger;
- Serious loss to bodily function;
- Serious loss of function to a body part or organ;
- Serious danger to the health of a fetus; or
- In the case of a pregnant woman:
  - Serious jeopardy to the health of the fetus;
  - One who is having contractions and there is inadequate time to effect a safe transfer to another Hospital before delivery; or
  - A transfer may pose a threat to the health or safety of the woman or unborn child.

**Emergency Services** – Treatment given in an Ambulance and a Hospital's emergency room or an independent freestanding emergency department. This includes evaluation of and treatment to stabilize the Emergency Medical Condition. An "independent freestanding emergency department" means a health care facility that is geographically separate, distinct and licensed separately from a Hospital and provides Emergency Services.

**Experimental or Investigational** – A drug, device, procedure, or treatment that We find is Experimental or Investigational because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the Illness or Injury involved;
- The needed approval by the FDA has not been given for marketing;
- A national medical or dental society or regulatory agency has stated in writing that it is Experimental or Investigational or suitable mainly for research purposes;
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- Written protocols or a written consent form used by a facility Provider state that it is Experimental or Investigational.

**Formulary Exclusions List** – A list of Prescription Drugs not covered under the plan. This list is subject to change.

**Generic Prescription Drug** – An FDA-approved drug with the same intended use as the brand-name product. It is considered to be as effective as the brand-name product and offers the same:

- Dosage;
- Safety;
- Strength;

- Quality; and
- Performance.

**Grievance** - A written Complaint or, if the Complaint involves an Urgent Care request submitted by or on behalf of the Member, an oral Complaint regarding availability, delivery or quality of Health Care Services, or matters pertaining to the contractual relationship between the Member and Peak Health, or a request for an approved exception to obtain Covered Services from an Out-of-Network Provider.

**Health Professional** – A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, Physicians, nurses, Dental Providers, vision care Providers, and physical therapists.

**Home Health Aide** – A Health Professional that provides services through a Home Health Care Agency. The services that they provide are not required to be performed by an R.N., L.P.N., or L.V.N. A Home Health Aide primarily aids You in performing the normal activities of daily living while You recover from an Injury or Illness.

**Home Health Care Agency** – An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

**Home Health Care Plan** – A plan of services prescribed by a Physician (or other Health Professional) to be provided in the home setting. These services are usually provided after Your discharge from a Hospital or if You are Homebound.

**Homebound** – A condition due to an illness or injury which restricts ability to leave the residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if the individual has a condition that leaving home is medically contraindicated (e.g. quarantined due to immunocompromised host, communicable disease).

**Hospice Benefit Period** – A period that begins on the date Your Physician certifies that You have a Terminal Illness. It ends after 6 months (or later for which Your treatment is certified) or on Your death; if sooner.

**Hospice Care** – Care designed to give supportive care to people in the final phase of a Terminal Illness and focus on comfort and quality of life, rather than cure

**Hospice Care Agency** – An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide Hospice Care. These services may be available in Your home or inpatient setting.

**Hospice Care Program** – A program prescribed by a Physician or other Health Professional to provide Hospice Care and supportive care to their families.

**Hospice Facility** – An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide Hospice Care.

**Hospital** – An institution licensed as a Hospital by applicable state and federal laws, and is accredited as a Hospital by The Joint Commission (TJC).

Hospital does not include a:

- Convalescent facility;
- Rest facility;
- Nursing facility;
- Facility for the aged;
- Psychiatric Hospital;
- Residential Treatment Facility for Substance Related Disorders;
- Residential Treatment Facility for Mental Health Disorders;
- Extended care facility;
- Intermediate care facility; or
- Skilled Nursing Facility.

**Hospital Stay** – This is Your Stay of 18 or more hours in a row as a resident bed patient in a Hospital.

**Illness or Illnesses** – Poor health resulting from disease of the body or mind.

**In-Network Dental Provider** – A Dental Provider listed in the Directory for Your plan.

**In-Network Pharmacy** – A Retail Pharmacy, Mail Order Pharmacy or Specialty Pharmacy that has contracted with Peak Health, an affiliate, or a third-party vendor, to provide outpatient Prescription Drugs to You.

**In-Network Provider** – A Provider listed in the Directory for Your plan.

**Injectable Drug(s)** – **These are drugs** administered by injection into the body, including intravenous (IV), intramuscular (IM), subcutaneous (SC), or intradermal administration. Injectable drugs are administered by a health care provider in a physician's office, clinic, outpatient facility, or other health care setting, and do not include vaccines or immunizations.

**Injury or Injuries** – Physical damage done to a person or part of their body.

**Intensive Care Unit** – A ward, unit, or area in a Hospital which is set aside to provide continuous specialized or intensive care services to Your because Your Illness or Injury is severe enough to require such care.

**Intensive Outpatient Program (IOP)** – The clinical treatment provided must be:

- No more than 5 days per week;
- No more than 19 hours per week; and
- A minimum of 2 hours each treatment day.

Services must be Medically Necessary and delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a Mental Health Disorder or Substance Related Disorder and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

**Jaw Joint Disorder** – This is:

- A disorder of the jaw joint;
- A Myofascial pain dysfunction (MPD) of the jaw; or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

**L.P.N.** – A licensed practical nurse or a licensed vocational nurse.

**Mail Order Pharmacy** – A Pharmacy where Prescription Drugs are legally dispensed by mail or other carrier.

**Maximum Out-of-Pocket Limit** – The maximum out-of-pocket amount for payment of Copayments and Coinsurance including any Policy Year Deductible, to be paid by You or any Covered Dependents per Policy Year for Eligible Health Services.

**Medically Necessary/Medical Necessity** – Health care services or supplies that prevent, evaluate, diagnose or treat an Illness, Injury, disease or its symptoms, and that are all of the following, as determined by Us within Our discretion:

- In accordance with “generally accepted standards of medical practice”;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your Illness, Injury or disease;
- Not primarily for Your convenience, the convenience of Your Physician, or other health care Provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your Illness, Injury or disease.

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; and
- Following the standards set forth in Our clinical policies and applying clinical judgment.

**Important note:**

We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is Experimental or Investigational. They are subject to change. You can find these bulletins and other information at [peakhealth.org](http://peakhealth.org). You can also contact us. See the *How to Contact Us for Help* section.

**Medicare** – As used in this plan, Medicare means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

**Mental Health Disorder** – A Mental Health Disorder is, in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of Mental Health Disorder is in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

**Morbid Obesity/Morbidly Obese** – This means the Body Mass Index is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure;
- A heart or lung condition;
- Sleep apnea; or
- Diabetes.

## Definitions N-Z

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**Negotiated Charge** – In regard to one of the following:

**Health coverage**

This is either:

- The amount an In-Network Provider has agreed to accept; or
- The amount We agree to pay directly to an In-Network Provider or third-party vendor (including any administrative fee in the amount paid) for providing services, Prescription Drugs or supplies to Covered Persons in the plan. This does not include Prescription Drug services from an In-Network Pharmacy.

For surprise billing, calculations will be made based on the median contracted rate. We may enter into arrangements with In-Network Providers or others related to:

- The coordination of care for Covered Persons; and
- Improving clinical outcomes and efficiencies.

Some of these arrangements are called:

- Value-based contracting; or
- Risk sharing.

These arrangements will not change the Negotiated Charge under this plan.

**Prescription Drug coverage**

In-network Pharmacy – The amount We established for each Prescription Drug obtained from an in-network Pharmacy under this plan. This Negotiated Charge may reflect amounts We agreed to pay directly to the In-Network Pharmacy or to a third-party vendor for the Prescription Drug, and may include a rebate, an additional service or risk charge set by us. The Negotiated Charge for Pharmacy must be at a minimum of NADAC (National Average Drug Acquisition Cost) for the Prescription Drug or Pharmacy service at the time the drug is administered or dispensed, plus a professional dispensing fee of \$10.49. Additionally, all rebates must be passed back at point-of-sale.

**Non-Preferred Drug** – A Prescription Drug or device that may have a higher out-of-pocket cost than a Preferred Drug.

**Out-of-Network Dental Provider** – A Dental Provider who is not a Select Care Dental Provider or an In-Network Dental Provider and does not appear in the Directory for Your plan.

**Out-of-Network Pharmacy** – A Pharmacy that is not an In-Network Pharmacy and does not appear in the Directory for Your plan.

**Out-of-Network Provider** – A Provider who is not a In-Network Provider and does not appear in the Directory for Your plan.

**Partial Hospitalization Treatment** – Clinical treatment provided must be no more than 5 days per week, minimum of 4 hours each treatment day. Services must be Medically Necessary and provided by a Behavioral Health Provider with the appropriate license or credentials. Services are designed to address a Mental Health Disorder or Substance Related Disorder and may include:

- Group, individual, family or multi-family group psychotherapy;
- Psycho-educational services; or
- Adjunctive services such as medication monitoring.

Care is delivered according to accepted medical practice for the condition of the person.

**Pharmacy** – An establishment where Prescription Drugs are legally dispensed. This includes a in-network Retail Pharmacy, Mail Order Pharmacy and Specialty Pharmacy. It also includes an out-of-network Retail Pharmacy and Mail Order Pharmacy.

**Physician** – A skilled Health Professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

**Policyholder** – An individual who is enrolled under the terms and conditions of this Policy.

**Precertification or Precertify** – A requirement that You or Your Physician contact Peak Health before You receive coverage for certain services. This may include a determination by Us as to whether the service is Medically Necessary and eligible for coverage.

**Preferred Drug** – A Prescription Drug or device that may have a lower out-of-pocket cost than a Non-Preferred Drug.

**Navitus Marketplace Select Formulary**– A list of Prescription and over-the-counter (OTC) drugs and devices established by Navitus (Peak Health’s PBM). It does not include all Prescription and OTC drugs and devices. A copy of the Navitus Marketplace Select Formulary is available at Your request. You can also find it on the Peak Health website at [peakhealth.org](https://peakhealth.org).

**Preferred In-Network Pharmacy** – A network Retail Pharmacy that Peak Health has identified as a Preferred In-Network Pharmacy.

**Premium** – The amount You or the Policyholder are required to pay to Peak Health to continue coverage.

**Prescriber** – Any Provider acting within the scope of his or her license, who has the legal authority to write an order for outpatient Prescription Drugs.

**Prescription** – In regard to one of the following:

**As to hearing care:**

A written order for the dispensing of Prescription electronic hearing aids by otolaryngologist, otologist or audiologist.

**As to Prescription Drugs:**

A written order for the dispensing of a Prescription Drug or device by a Prescriber. If it is a verbal order, it must promptly be put in writing by the In-Network Pharmacy.

**As to vision care:**

A written order for the dispensing of Prescription lenses or Prescription contact lenses by an ophthalmologist or optometrist.

**Prescription Drug** – An FDA approved drug or biological which can only be dispensed by Prescription.

**Provider(s)** – A Physician, other Health Professional, Hospital, Skilled Nursing Facility, Home Health Care Agency, Pharmacy, or other entity or person licensed or certified under applicable state and federal law to provide health care services to You. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

**Psychiatric Hospital** – An institution specifically licensed as a Psychiatric Hospital by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of Substance Related Disorders and Mental Health Disorders.

**Psychiatrist** – A Psychiatrist generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

**Our Reimbursement Policies**

We reserve the right to apply Our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the Allowed Amount. These policies consider:

- The duration and complexity of a service;
- When multiple procedures are billed at the same time, whether additional overhead is required;
- Whether an assistant surgeon is necessary for the service;
- If follow-up care is included;
- Whether other characteristics modify or make a particular service unique;
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided; and
- The educational level, licensure or length of training of the Provider.

Our reimbursement policies are based on Our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate;
- Generally accepted standards of medical and dental practice; and
- The views of Physicians and Dentists practicing in the relevant clinical areas.

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

**Get the most value out of Your benefits**

We have online tools to help you decide whether to get care and if so, where. Log in to Your Peak Health website at [peakhealth.org](https://peakhealth.org). The website contains additional information that can help you determine the cost of a service or supply.

**R.N.** – A registered nurse.

**Residential Treatment Facility** – In regards to one of the following:

**For Mental Health Disorders**

An institution specifically licensed as a Residential Treatment Facility by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by Peak Health or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC);
- The Committee on Accreditation of Rehabilitation Facilities (CARF);
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP); or
- The Council on Accreditation (COA).

In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating Mental Health Disorders:

- A Behavioral Health Provider must be actively on duty 24 hours per day for 7 days a week;
- The patient must be treated by a Psychiatrist at least once per week;
- The medical director must be a Psychiatrist; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed Residential Treatment Facility or otherwise licensed institution).

**For Substance Related Disorders**

An institution specifically licensed as a Residential Treatment Facility by applicable state and federal laws to provide for Substance Related Disorder residential treatment programs. And is credentialed by Peak Health or accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC);

- The Committee on Accreditation of Rehabilitation Facilities (CARF);
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP); or
- The Council on Accreditation (COA).

In addition to the above requirements, an institution must meet the following for Substance Related Disorder residential treatment programs:

- A Behavioral Health Provider or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming;
- The medical director must be a Physician; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed Residential Treatment Facility or otherwise licensed institution).

In addition to the above requirements, an institution must meet the following for substance related Detoxification programs within a residential setting:

- An R.N. must be onsite 24 hours per day for 7 days a week within a residential setting; and
- Residential care must be provided under the direct supervision of a Physician.

**Respite Care** – This is care provided to You when You have a Terminal Illness for the sole purpose of providing temporary relief to Your family (or other care givers) from the daily demands of caring for You.

**Retail Pharmacy** – A community Pharmacy that dispenses outpatient Prescription Drugs.

**Room and Board** – A facility's charge for Your overnight Stay and other services and supplies expressed as a daily or weekly rate.

**Self-Injectable Drug(s)** – These are Prescription Drugs that are intended for You to self-administer by injection to a specific part of Your body to treat certain chronic medical conditions.

**Semi-Private Room Rate** – An institution's Room and Board charge for most beds in rooms with 2 or more beds. If there are no such rooms, Peak Health will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

**Skilled Nursing Facility** – A facility specifically licensed as a Skilled Nursing Facility by applicable state and federal laws to provide skilled nursing care. Skilled Nursing Facilities also include rehabilitation Hospitals, and portions of a rehabilitation Hospital and a Hospital designated for skilled or rehabilitation therapy services.

Skilled Nursing Facility does not include institutions that provide only:

- Minimal care;
- Custodial Care services;
- Ambulatory care; or

- Part-time care services.

It also does not include institutions that primarily provide for the care and treatment of Mental Health Disorders or Substance Related Disorders.

**Skilled Nursing Services** – Services provided by an R.N. or L.P.N. within the scope of his or her license.

**Sound Natural Teeth** – These are natural teeth. If there is a filling in a tooth, the major portion of the tooth must be present. A tooth cannot be decayed, abscessed, or defective. Sound Natural Teeth are not capped teeth, implants, crowns, bridges, or dentures.

**Specialist** – A Physician who practices in any generally accepted medical or surgical sub-specialty and is board-certified.

**Specialty Pharmacy** – A Pharmacy that fills Prescriptions for specialty drugs.

**Specialty Prescription Drug** – A Prescription Drug used to treat chronic and complex, or rare medical conditions and requires special handling or administration, provider care coordination, or patient education that cannot be provided by a non-Specialty Pharmacy or pharmacist.

**Stay** – A full-time inpatient confinement for which a Room and Board charge is made.

**Step Therapy** – A form of Precertification where You must try one or more required drug(s) before a Step Therapy drug is covered. The required drugs have FDA approval, may cost less and treat the same condition. If You don't try the appropriate required drug first, You may need to pay full cost for the Step Therapy drug.

**Substance Related Disorder** – A Substance Related Disorder, addictive disorder, or both, as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association.

**Surgery Center** – A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient Surgery services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

**Surgery, Surgeries or Surgical Procedures** – The diagnosis and treatment of Injury, deformity and disease by manual and instrumental means, such as:

- Cutting;
- Abrading;
- Suturing;
- Destruction;
- Ablation;
- Removal;

- Lasering;
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy);
- Correction of fracture;
- Reduction of dislocation;
- Application of plaster casts;
- Injection into a joint;
- Injection of sclerosing solution; or
- Otherwise physically changing body tissues and organs.

**Telemedicine** – A consultation between You and a Physician, Specialist, Behavioral Health Provider, or Telemedicine Provider who is performing a clinical medical or behavioral health service by means of electronic communication.

**Temporomandibular Joint Dysfunction (TMJ)** – This is a disorder of the jaw joint.

**Terminal Illness** – A medical prognosis that You are not likely to live more than 24 months.

**Therapeutic Drug Class** – A group of drugs or medications that have a similar or identical mode of action. They could be used for the treatment of the same or similar Illness or Injury.

**Urgent Admission** – This is an admission to the Hospital due to an Illness or Injury that is severe enough to require a Stay in a Hospital within 2 weeks from the date the need for the Stay becomes apparent.

**Urgent Care Facility** – A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an Urgent Condition.

**Urgent Condition** – An Illness or Injury that requires prompt medical attention but is not an Emergency Medical Condition.

**Value Prescription Drugs** – A group of medications determined by Us that may be available at a reduced Copayment and are noted on the Navitus Marketplace Select Formulary.

**Walk-In Clinic** – A health care facility that provides limited medical care on a scheduled and unscheduled basis. A Walk-In Clinic may be located in, near, or within a:

- Drug store;
- Pharmacy;
- Retail store; or
- Supermarket.

The following are not considered a Walk-In Clinic:

- Ambulatory surgical center;

- Emergency room;
- Hospital;
- Outpatient department of a Hospital;
- Physician's office; or
- Urgent Care Facility



