I. Definitions

The terms in this "Definitions" section have special meaning when capitalized and used in any section of this document.

- **Dependent:** A Member who meets the eligibility requirements as a Dependent under the plan.
- **Emergency Medical Condition:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person would have believed that the absence of immediate medical attention would result in any of the following:
    - Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
    - Serious impairment to bodily functions
    - Serious dysfunction of any bodily organ or part
    - A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:
        - The person is an immediate danger to himself or herself or to others
        - The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder
- **Emergency Services**: All of the following with respect to an Emergency Medical Condition:
    - A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
    - Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post Stabilization Care and not Emergency Services)
- **Family**: A Subscriber and all of his or her Dependents.
- **Health Plan**: The health care service plan that is issuing this coverage to you.
- **In-Network Hospital**: Any facility in the plan’s network or any facility the plan has agreed to reimburse for services rendered to you.
- **Medically Necessary**: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice

that are consistent with a standard of care in the medical community.

- **Medicare**: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-state renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant.
- **Member**: A person who is eligible and enrolled for coverage under this plan and for whom the plan has received applicable Premiums. This Summary of Coverage sometimes refers to a Member as "you."
- **Non-Plan Hospital**: a hospital other than a Plan Hospital.
- **Non-Plan Physician**: a physician other than a Plan Physician.
- **Non-Plan Provider**: A provider other than a Plan Provider.
- **Out-of-Area Urgent Care**: Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:
    - You are temporarily outside our Service Area
    - A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area
- **Plan Facility**: Any facility in the plan’s network and any facility the plan has agreed to reimburse for services rendered to you.
- **Plan Hospital**: Any hospital in the plan’s network and any hospital the plan has agreed to reimburse for services rendered to you.
- **Plan Optometrist**: An optometrist who is in the plan’s network and any optometrist the plan has agreed to reimburse for services rendered to you.
- **Plan Pharmacy**: A pharmacy in the plan’s network or any pharmacy the plan has agreed to reimburse for services rendered to you.
- **Plan Physician**: Any licensed physician who is in the plan’s network or any licensed physician the plan has agreed to reimburse for services rendered to you.
- **Plan Provider:** Any provider who is in the plan’s network or any provider the plan has agreed to reimburse for services rendered to you.
- **Plan Skilled Nursing Facility**: Any skilled nursing facility approved by the plan.
- **Post-Stabilization Care**: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized.
- **Preventive Care Services**: Services that do one or more of the following:

  - Protect against disease, such as in the use of immunizations
  - Promote health, such as counseling on tobacco use
  - Detect disease in its earliest stages before noticeable symptoms develop, such as screening for breast cancer
- **Primary Care Physicians**: Generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology.
- **Service Area**: The geographic areas where the plan is authorized to provide coverage of health care Services.
- **Services**: Health care services or items ("health care" includes both physical health care and mental health care) and behavioral health treatment covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits and Your Cost Share" section.
- **Skilled Nursing Facility**: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.
- **Spouse**: The Subscriber's legal husband or wife. For the purposes of this Summary of Coverage, the term "Spouse" includes the Subscriber's registered domestic partner who meets all of the requirements of Sections 297 or 299.2 of the California Family Code.
- **Stabilize**: To provide the medical treatment of the Emergency Medical Condition that is necessary to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).
- **Subscriber**: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber.
- **Urgent Care**: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

II. Covered Benefits

The plan covers all Medically Necessary basic health care services including all of the following:

- Physician services, including consultation and referral
- Hospital inpatient services and ambulatory care services
- Diagnostic, laboratory and diagnostic and therapeutic radiologic services
- Home health services
- Preventive health services
- Emergency health services, including ambulance and ambulance transport services and out-of-area coverage
- Hospice care

The remainer of this “Covered Benefits” section provides more detail regarding the services covered, subject to the "Exclusions and Limitations section.

Preventive Care Services

The plan covers a variety of Preventive Care Services, including but not limited to:

- Routine physical maintenance exams, including well- woman exams (refer to "Outpatient Care")
- Scheduled routine prenatal exams (refer to "Outpatient Care")
- Well-child exams (refer to "Outpatient Care")
- Health education counseling programs (refer to "Health Education")
- Immunizations (refer to "Outpatient Care")
- Routine preventive imaging and laboratory Services (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Outpatient and Ambulatory Service Facility Care

The plan covers outpatient and ambulatory service facility care, including:

- Primary and specialty care consultations, evaluations, and treatment (other than those described below in this "Outpatient Care" section)
- Preventive Care Services, including routine physical maintenance exams, including well-woman exams
- Screening and counseling Services, such as obesity counseling, routine vision and hearing screenings, health education, and depression screening
- Covered outpatient services furnished and billed by an outpatient facility, including any facility fees
- Well-child preventive exams for Members
- The normal series of regularly scheduled preventive prenatal care exams
- The first postpartum follow-up consultation and exam
- Alcohol and substance abuse screening

- Developmental screenings to diagnose and assess potential developmental delays
- Immunizations (including the vaccines)
- Flexible sigmoidoscopies
- Screening colonoscopies
- Allergy injections (including allergy serum)
- Outpatient surgery
- Outpatient procedures (other than surgery)
- Urgent Care consultations, evaluations, and treatment
- Emergency Department visits
- House calls when care can best be provided in your home
- Acupuncture Services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain)
- Blood, blood products, and their administration
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in Plan Provider's medical office of during a home visit. These include tuberculosis tests, administered chemotherapy drugs, and all other administered drugs.
- Tuberculosis tests
- Administered drugs
- Some types of outpatient consultations, evaluations, and treatment may be available as group appointments
- Coverage for Services related to "Outpatient Care" described in other sections

Coverage for Services related to "Outpatient Care" described in other sections:

The following types of outpatient Services are covered only as described under these headings in this "Covered Benefits" section:

- Bariatric Surgery
- Behavioral Health Treatment for Pervasive Developmental Disorder or Autism
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Durable Medical Equipment

- Family Planning Services
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Mental Health Services
- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures
- Outpatient Prescription Drugs, Supplies, and Supplements
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Rehabilitative and Habilitative Services
- Services in Connection with a Clinical Trial
- Transplant Services
- Vision Services

Hospital Inpatient Care

The plan coves the following inpatient Services when the Services are generally and customarily provided by acute care general hospitals inside the plan's Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Physician Services, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with the plan's drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, please refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Covered Benefits" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans
- Blood, blood products, and their administration
- Obstetrical care and delivery (including cesarean section)

- Behavioral health treatment for pervasive developmental disorder or autism
- Respiratory therapy
- Medical social services and discharge planning
- Coverage for Services related to "Hospital Inpatient Care" described in other sections

Coverage for Services related to “Hospital Inpatient Care” described in other sections:

The following types of inpatient Services are covered only as described under the following headings in this "Covered Benefits" section:

- Bariatric Surgery
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Hospice Care
- Mental Health Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Rehabilitative and Habilitative Services
- Services in Connection with a Clinical Trial
- Skilled Nursing Facility Care
- Transplant Services

Ambulance Services

Emergency

The plan covers the Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- A reasonable person would have believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

Nonemergency

Inside the plan’s Service Area, the plan cover nonemergency ambulance and psychiatric transport van Services if your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered

only when the vehicle transports you to or from covered Services.

Ambulance Services exclusion

Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van) is not covered.

Bariatric Surgery

The plan covers hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures, and Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if the following requirements are met:

- You complete a plan-approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success
- An in-network provider who is a specialist in bariatric care determines that the surgery is Medically Necessary

If you live 50 miles or more from the facility to which you are referred for a covered bariatric surgery, the plan will reimburse you for certain travel and lodging expenses if you receive prior written authorization from the plan and send the plan adequate documentation including receipts. The plan will not, however, reimburse you for any travel or lodging expenses if you were offered a referral to a facility that is less than 50 miles from your home.

Coverage for Services related to "Bariatric Surgery" described in other sections

Coverage for the following Services is described under these headings in this "Covered Benefits " section:

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Behavioral Health Treatment for Pervasive Developmental Disorder or Autism

The following terms have special meaning when capitalized and used in this "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" section:

- "Qualified Autism Service Provider" means a provider who has the experience and competence to design, supervise, provide, or administer treatment for pervasive developmental disorder or autism and is either of the following:
    - a person, entity, or group that is certified by a national entity (such as the Behavior Analyst Certification Board) that is accredited by the National Commission for Certifying Agencies
    - a person licensed in California as a physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist

- "Qualified Autism Service Professional" means a person who meets all of the following criteria:
    - provides behavioral health treatment
    - is employed and supervised by a Qualified Autism Service Provider
    - provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
    - is a behavioral health treatment provider approved as a vendor by a California regional center to provide Services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations
    - has training and experience in providing Services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code
- "Qualified Autism Service Paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:
    - is employed and supervised by a Qualified Autism Service Provider
    - provides treatment and implements Services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
    - meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code
    - has adequate education, training, and experience, as certified by a Qualified Autism Service Provider

The plan covers behavioral health treatment for pervasive developmental disorder or autism (including applied behavior analysis and evidence-based behavior intervention programs) that develops or restores, to the maximum extent practicable, the functioning of a person with pervasive developmental disorder or autism and that meets all of the following criteria:

- The treatment is prescribed by a Plan Physician, or is developed by a Plan Provider who is a psychologist
- The treatment is provided under a treatment plan prescribed by a Plan Provider who is a Qualified Autism Service Provider
- The treatment is administered by a Plan Provider who is one of the following:
- a Qualified Autism Service Provider
- a Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider
- a Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service Provider

- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the Member being treated
- The treatment plan is reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate
- The treatment plan requires the Qualified Autism Service Provider to do all of the following:
  - Describe the Member's behavioral health impairments to be treated
  - Design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported
  - Provide intervention plans that utilize evidence- based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism
  - Discontinue intensive behavioral intervention Services when the treatment goals and objectives are achieved or no longer appropriate
- The treatment plan is not used for either of the following:
  - for purposes of providing (or for the reimbursement of) respite care, day care, or educational services
  - to reimburse a parent for participating in the treatment program

Chemical Dependency Services

Inpatient detoxification

The plan covers hospitalization for medical management of withdrawal symptoms, including room and board, Physician Services, drugs, dependency recovery Services, education, and counseling.

Outpatient chemical dependency care

The plan covers the following Services for treatment of chemical dependency:

- Day-treatment programs
- Intensive outpatient programs
- Individual and group chemical dependency counseling
- Medical treatment for withdrawal symptoms

Transitional residential recovery Services

The plan covers chemical dependency treatment in a nonmedical transitional residential recovery setting. These settings provide counseling and support services in a structured environment.

- Coverage for Services related to "Chemical Dependency Services" described in

other sections

Coverage for the following Services is described under these headings in this "Covered Benefits" section

Coverage for the following Services is described under these headings in this “Covered Benefits" section:

- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Chemical dependency Services exclusion
- Services in a specialized facility for alcoholism, drug abuse, or drug addiction except as otherwise described in this "Chemical Dependency Services" section

Dental and Orthodontic Services

Pediatric services

The plan covers the same benefits for pediatric oral care as are covered under the dental benefit received by children under the California Medi-Cal program as of 2014, including the provision of medically necessary orthodontic care provided pursuant to the federal Children’s Health Insurance Program Reauthorization Act of 2009.

These services include, but are not limited to:

- Oral exams
- Fluoride treatments
- Restorative services, such as amalgams, composites, and crowns
- Scaling and root planning
- X-rays
- Root canals
- Dentures
- Extractions
- Emergency dental services
- Dental anesthesia, if medically necessary
- Dental services related to cleft palate surgery

Adult Services

The plan does not cover most adult dental and orthodontic Services. However, the plan covers dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if your provider provides the Services or if the plan authorizes a referral to a dentist.

For dental procedures at an in-network facility, the plan provides general anesthesia and the facility's Services associated with the anesthesia if all of the following are true:

- You are developmentally disabled, or your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

The plan does not cover any other Services related to the dental procedure, such as the dentist's Services.

The plan covers dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic Services, if they meet all of the following requirements:

- The Services are an integral part of a reconstructive surgery for cleft palate that the plan is covering under "Reconstructive Surgery" in this "Covered Benefits " section
- An in-network Provider provides the Services or the plan authorizes a referral to an out-of-network Provider who is a dentist or orthodontist

Coverage for Services related to "Dental and Orthodontic Services" described in other sections

Coverage for the following Services is described under these headings in this "Benefits and Your Cost Share" section:

- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient administered drugs (refer to "Outpatient Care"), except that we cover outpatient administered drugs under "Dental anesthesia" in this "Dental and Orthodontic Services" section
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Dialysis Care

The plan covers acute and chronic dialysis Services if all of the following requirements are met:

- The Services are provided inside the plan’s Service Area
- You satisfy all medical criteria developed by the plan and by the facility providing the dialysis
- An in-network provider provides a written referral for care at the facility

After you receive appropriate training at a dialysis facility designated by the plan, the plan also covers equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside our Service Area. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. The plan decides whether to rent or purchase the equipment and supplies, and the plan selects

the vendor. You must return the equipment and any unused supplies to the plan or pay the plan the fair market price of the equipment and any unused supply when the plan is no longer covering them.

Coverage for Services related to "Dialysis Care" described in other sections

Coverage for the following Services is described under these headings in this "Covered Benefits" section:

- Durable medical equipment for use outside an institutional setting (refer to "Durable Medical Equipment")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Dialysis Care exclusions

The plan does not cover:

- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Durable Medical Equipment for Use Outside of an Institutional Setting

The plan covers durable medical equipment for use outside of an institutional setting. Durable medical equipment is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use outside an institutional setting.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. The plan decides whether to rent or purchase the equipment, and the plan selects the vendor. You must return the equipment to the plan or pay the plan the fair market price of the equipment if the plan is no longer covering it.

- Covered durable medical equipment items include the following:
  - Mobility devices, including walkers and manual and power wheelchairs and scooters
  - Augmented communications devices, such as speech generating devices, communications boards, and apps.
  - Continuous positive airway pressure (CPAP) machines
  - Portable oxygen
  - Hospital beds
  - For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)

- Infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other drugs)
- Standard curved handle or quad canes and replacement supplies
- Standard or forearm crutches and replacement supplies
- Dry pressure pads for a mattress
- Nebulizers and supplies
- Peak flow meters
- IV poles
- Tracheostomy tube and supplies
- Enteral pumps and supplies
- Bone stimulators
- Cervical traction (over door)
- Phototherapy blankets for treatment of jaundice in newborns

Durable medical equipment exclusions

- Neuromodulators
- Comfort, convenience, or luxury equipment or features
- Repair or replacement of equipment due to loss or misuse

Family Planning Services

The plan covers the following family planning Services:

- Family planning counseling
- Consultations for internally implanted time-release contraceptives or intrauterine devices
- Female sterilization procedures
- Male sterilization procedures
- Termination of pregnancy
- Services to treat iatrogenic infertility
- Services to evaluate and diagnose infertility
- The following services to treat infertility:
  - Artificial insemination
  - Three (3) attempts to retrieve gametes (sperm or eggs)
  - Three (3) attempts to create embryos
  - Three (3) rounds of pre-transfer testing

- Cryopreservation of gametes and embryos
- Two years of storage for cryopreserved embryos
- Unlimited storage for cryopreserved gametes
- Unlimited embryo transfers
- Two (2) vials of donor sperm
- Ten (10) donor eggs
- Surrogacy coverage for the aforementioned services, as well as health testing of the surrogate for each attempted round of covered services

- Coverage for Services related to "Family Planning Services" described in other sections under these headings in this "Covered Benefits " section:
  - Outpatient laboratory and imaging services associated with family planning services (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
  - Outpatient contraceptive drugs and devices (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Family Planning Services exclusions
  - Reversal of voluntary sterilization
  - Administrative costs associated with surrogacy
  - Financial compensation to a surrogate

Health Education

The plan covers a variety of health education counseling, programs, and materials that your provider provides during a visit covered under another part of this "Covered Benefits " section.

The plan also covers a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, weight loss, stress management, and chronic conditions (such as diabetes and asthma).

Hearing Services

The plan covers internally-implanted devices as described in the "Prosthetic and Orthotic Devices" section). The plan also covers the following:

- Routine hearing screenings that are Preventive Care Services
- One hearing aid per ear every three (3) years
- Hearing exams to determine the need for hearing correction
- Coverage for Services related to "Hearing Services" described in other sections
- Coverage for the following Services is described under these headings in this "Covered Benefits" section:

- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Covered Benefits" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. The plan covers home health care at no charge only if all of the following are true:

- You are substantially confined to your home (or a friend's or relative's home)
- Your condition requires the Services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- Your provider determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home

The plan covers only part-time or intermittent home health care, as follows:

- Up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health aide
- Up to three visits per day (counting all home health visits)
- Up to 100 visits per calendar year (counting all home health visits)

Note: If a visit by a nurse, medical social worker, physical, occupational, or speech therapist lasts longer than two hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four hours counts as a separate visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as two visits. Also, each person providing Services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two hours, that counts as two visits.

Coverage for Services related to "Home Health Care" described in other sections

Coverage for the following Services is described under these headings in this "Covered Benefits" section:

- Behavioral health treatment for pervasive developmental disorder or autism (refer to "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism")
- Dialysis care (refer to "Dialysis Care")

- Durable medical equipment (refer to "Durable Medical Equipment for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")Home health care exclusions

Home health care exclusions

- Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if the plan would cover the care if it were provided by a qualified medical professional in a hospital or a Skilled Nursing Facility
- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the Member's family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

The plan covers the hospice Services listed below at no charge only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided by a licensed hospice agency
- The Services are necessary for the palliation and management of your terminal illness and related conditions

If all the above requirements are met, the plan covers the following hospice Services, which are available on a 24- hour basis if necessary for your hospice care:

- Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services

- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with the plan's drug formulary guidelines. You must obtain these drugs from Plan Pharmacies. Certain drugs are limited to a maximum 30-day supply in any 30-day period
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling
- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms:
    - nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
    - short-term inpatient care required at a level that cannot be provided at home

Infusion Therapy

This benefit is provided for outpatient professional services, supplies, drugs, and solutions required for infusion therapy. Infusion therapy (also known as "intravenous therapy") is the administration of fluids into a vein by means of a needle or catheter, most often used for the following purposes:

- To maintain fluid and electrolyte balance
- To correct fluid volume deficiencies after excessive loss of body fluids
- Members that are unable to take sufficient volumes of fluids orally
- Prolonged nutritional support for members with gastrointestinal dysfunction

Mental Health and Substance Use Disorder Services

- The plan covers Services specified in this section only when the Services are for the diagnosis or treatment of a Mental Health or Substance Use Disorder. For purposes of this section, "Mental Health and Substance Use Disorders" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The plan does not cover services for conditions that the DSM identifies as something other than a "mental health condition" or a "substance use disorder." For example, the DSM identifies relational problems as something other than a "mental health condition," so the plan does not cover services (such as couples counseling

or family counseling) for relational problems.

Outpatient mental health Services

The plan covers the following Services when provided by Plan Physicians or other appropriate Plan Providers:

- Individual and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

Note: Outpatient intensive psychiatric treatment programs are not covered under this "Outpatient mental health Services" section (refer to "Intensive psychiatric treatment programs" under "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in this "Mental Health Services" section).

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs

Inpatient psychiatric hospitalization. The plan covers inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other appropriate Plan Providers.

Intensive psychiatric treatment programs. The plan covers at no charge the following intensive psychiatric treatment programs at a Plan Facility:

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a- day monitoring by clinical staff for stabilization of an acute psychiatric crisis
- Psychiatric observation for an acute psychiatric crisis

Coverage for Services related to "Mental Health Services" described in other sections

Coverage for the following Services is described under these headings in this "Covered Benefits" section:

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Ostomy and Urological Supplies

Inside the plan’s Service Area, the plan covers ostomy and urological supplies prescribed in accord with our soft goods formulary guidelines at no charge. The plan selects the vendor, and coverage is limited to the standard supply that adequately meets your medical needs.

Ostomy and urological supplies exclusion

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

The plan covers the following Services only when prescribed as part of care covered under other headings in this "Covered Benefits" section:

- Imaging Services that are Preventive Care Services:
  - preventive mammograms
  - preventive abdominal aortic aneurysm ultrasound screenings
  - bone density CT scans
  - bone density DEXA scans
- All other CT scans, and all MRIs and PET scans
- All other imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds
- Nuclear medicine
- Laboratory tests:
  - laboratory tests to monitor the effectiveness of dialysis
  - fecal occult blood tests
  - routine laboratory tests and screenings that are Preventive Care Services, such as cervical cancer screenings, prostate specific antigen tests,

    cholesterol tests (lipid panel and profile), fasting blood glucose tests, glucose tolerance tests, certain sexually transmitted disease (STD) tests, genetic testing for breast cancer susceptibility, and HIV tests

    all other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)
- Routine preventive retinal photography screenings
- All other diagnostic procedures provided by Plan Providers who are not physicians (such as EKGs and EEGs)
- Radiation therapy
- Ultraviolet light treatments

Outpatient Prescription Drugs, Supplies, and Supplements

The plan covers outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section when prescribed as follows and obtained at a Plan Pharmacy or through the plan’s mail-order service:

- Items prescribed by Plan Physicians in accord with the plan’s drug formulary guidelines
- Items prescribed by the following Non–Plan Providers unless a Plan Physician determines that the item is not Medically Necessary or the drug is for a sexual

dysfunction disorder:

- Dentists if the drug is for dental care
- Non–Plan Physicians if the plan authorizes a written referral to the Non–Plan Physician and the drug, supply, or supplement is covered as part of that referral
- Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section

How to obtain covered items

You must obtain covered items at a Plan Pharmacy or through the plan's mail-order service unless you obtain the item as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section.

Plan's drug formulary

The plan's drug formulary includes the list of drugs that the plan covers. The drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on the plan's drug formulary for your condition) if they would otherwise be covered and a Plan Physician determines that they are Medically Necessary.

General rules about coverage

The plan covers the following outpatient drugs, supplies, and supplements as described in this "Outpatient Prescription Drugs, Supplies, and Supplements" section:

- Drugs for which a prescription is required by law. The plan also covers certain drugs that do not require a prescription by law if they are listed on the plan's drug formulary
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs

Continuity drugs

If the plan changes its coverage to exclude a drug that the plan has been covering and providing to you, the plan will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug.

Coverage for Services related to "Outpatient Prescription Drugs, Supplies, and Supplements" described in other sections

Coverage for the following Services is described under these headings in this "Covered Benefits" section:

- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment for Home Use")

- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care")
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment")
- Outpatient administered drugs (refer to "Outpatient Care")

Outpatient prescription drugs, supplies, and supplements exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the drug is listed on our drug formulary or one of the ingredients requires a prescription by law
- Drugs prescribed to shorten the duration of the common cold

Prosthetic and Orthotic Devices

The plan does not cover most prosthetic and orthotic devices, but the plan does cover devices as described in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor the plan selects

Coverage includes fitting and adjustment of these devices, their repair or replacement, and Services to determine whether you need a prosthetic or orthotic device. If the plan covers a replacement device, then you pay the Cost Share that you would pay for obtaining that device.

Internally implanted devices

The plan covers prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that the plan covers under another section of this "Covered Benefits" section.

External devices

The plan covers the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres required

to hold a prosthesis every 12 months

- Podiatric devices (including footwear) to prevent or treat foot complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

Coverage for Services related to "Prosthetic and Orthotic Devices" described in other sections

Coverage for the following Services is described under these headings in this "Covered Benefits" section:

- Contact lenses to treat aniridia or aphakia (refer to "Vision Services")

Prosthetic and orthotic devices exclusions

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section
- Comfort, convenience, or luxury equipment or features
- Shoes or arch supports, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for foot complications
- Repair or replacement of device due to loss or misuse

Reconstructive Surgery

The plan covers the following reconstructive surgery Services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, the plan covers reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

Coverage for Services related to "Reconstructive Surgery" described in other sections

Coverage for the following Services is described under these headings in this "Covered Benefits " section:

- Dental and orthodontic Services that are an integral part of reconstructive surgery for cleft palate (refer to "Dental and Orthodontic Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and

Special Procedures")

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")

Reconstructive surgery exclusions

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance
- Surgery that is performed to alter or reshape normal structures of the body to improve appearance

Rehabilitative and Habilitative Services

The plan covers the Services described in this "Rehabilitative and Habilitative Services" section if all the following requirements are met:

- The Services are to address a health condition
- The Services are to help you partially or fully acquire or improve skills and functioning needed to perform activities of daily living, to the maximum extent practical

The plan covers the following Services:

- Individual outpatient physical, occupational, and speech therapy r
- Group outpatient physical, occupational, and speech therapy r
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day- treatment program
- Physical, occupational, and speech therapy provided in a Skilled Nursing Facility (subject to the day limits described in the "Skilled Nursing Facility Care" section)
- Physical, occupational, and speech therapy provided in an inpatient hospital (including treatment in an organized multidisciplinary rehabilitation program)

Coverage for Services related to "Rehabilitative and Habilitative Services" described in other sections

- Behavioral health treatment for pervasive developmental disorder or autism (refer to "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism")
- Home health care (refer to "Home Health Care")
- Durable medical equipment (refer to "Durable Medical Equipment")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Rehabilitative and Habilitative Services exclusions

- Items and services that are not health care items and services (for example, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including vocational training)

Services in Connection with a Clinical Trial

The plan covers Services you receive in connection with a clinical trial if all of the following requirements are met:

- The plan would have covered the Services if they were not related to a clinical trial
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
  - A Plan Provider makes this determination
  - You provide us with medical and scientific information establishing this determination
- If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live
- The clinical trial is an Approved Clinical Trial

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other) life-threatening condition and it meets one of the following requirements:

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having an investigational new drug application
- The study or investigation is approved or funded by at least one of the following:
  - the National Institutes of Health
  - the Centers for Disease Control and Prevention
  - the Agency for Health Care Research and Quality
  - the Centers for Medicare & Medicaid Services
  - a cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - the Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S.

Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review

Services in connection with a clinical trial exclusions

- The investigational Service
- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management

Skilled Nursing Facility Care

Inside the plan's Service Area, the plan covers up to 100 days per benefit period (including any days the plan covered under any other evidence of coverage offered by the plan) of skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

The plan covers the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our durable medical equipment formulary if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Blood, blood products, and their administration
- Medical supplies
- Behavioral health treatment for pervasive developmental disorder or autism
- Respiratory therapy

Coverage for Services related to "Skilled Nursing Facility Care" described in other sections

Coverage for the following Services is described under these headings in this "Covered Benefits" section:

- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Physical, occupational, and speech therapy (refer to "Rehabilitative and Habilitative Services")

Transplant Services

The plan covers transplants of organs, tissue, or bone marrow if a Plan Provider provides a written referral for care to a transplant facility. After the referral to a transplant facility, the following applies:

- If either your provider or the referral facility determines you do not satisfy its respective criteria for a transplant, the plan will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with the plan's guidelines for Services for living transplant donors, the plan provides certain donation-related Services for a donor, or an individual identified as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of complications.

The plan will provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with the plan's guidelines for donor Services at no charge.

Coverage for Services related to "Transplant Services" described in other sections

Coverage for the following Services is described under these headings in this "Covered Benefits" section:

- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Treatment for Temporomandibular Joint Disorders

The plan covers medically necessary treatments and surgical procedures for any condition directly affecting the upper or lower jawbone, or associated bone joints.

Vision Services

The plan does not cover eyeglasses or contact lenses (except for special contact lenses described in this "Vision Services" section). However, the plan does cover the following:

- Routine vision screenings that are Preventive Care Services
- Eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses

Special contact lenses for aniridia and aphakia

The plan covers the following special contact lenses when prescribed by a Plan Physician or Plan Optometrist:

- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris).
- Up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year to treat aphakia (absence of the crystalline lens of the eye).

Coverage for Services related to "Vision Services" described in other sections

Coverage for the following Services is described under other headings in this "Covered Benefits" section:

- Services related to the eye or vision other than Services covered under this "Vision Services" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Covered Benefits" section)

Vision Services exclusions

- Industrial frames
- Eyeglass lenses and frames
- Contact lenses, including fitting and dispensing (except for special contact lenses to treat aphakia or aniridia as described under this "Vision Services" section)
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low-vision devices

III. Exclusions and Limitations

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "Covered Benefits" section.

Certain exams and Services

Physical exams and other Services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation. This exclusion does not apply if a Plan Physician determines that the Services are Medically Necessary.

Chiropractic Services

Chiropractic Services and the Services of a chiropractor, unless you have coverage for supplemental chiropractic Services.

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, except that

this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "Covered Benefits" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Covered Benefits" section:
  - testicular implants implanted as part of a covered reconstructive surgery
  - breast prostheses needed after a mastectomy
  - prostheses to replace all or part of an external facial body part

Custodial care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, Skilled Nursing Facility, or inpatient hospital care.

Dental and orthodontic Services

Dental and orthodontic Services such as X-rays, appliances, implants, Services provided by dentists or orthodontists, dental Services following accidental injury to teeth, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to Services covered under "Dental and Orthodontic Services" in the "Covered Benefits" section.

Disposable supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies.

This exclusion does not apply to disposable supplies covered under "Durable Medical Equipment for Home Use," "Home Health Care," "Hospice Care," "Ostomy and Urological Supplies," and "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Covered Benefits" section.

Experimental or Investigational Services

A Service is experimental or investigational if the plan determines that one of the following is true:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)
- It requires government approval that has not been obtained when the Service is to be provided

This exclusion does not apply to any of the following:

- Experimental or investigational Services when an investigational application has

been filed with the federal Food and Drug Administration (FDA) and the manufacturer or other source makes the Services available to you or your Plan Provider through an FDA-authorized procedure, except that the plan does not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol

- Services covered under "Services in Connection with a Clinical Trial" in the "Covered Benefits" section

This exclusion does not apply if the plan's external, independent review or the independent medical review by the California Department of Managed Health Care overturns a plan's coverage denial that was based on the treatment being experimental or investigational.

Hair loss or growth treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth. This exclusion does not apply to Services covered under the "Covered Benefits" section.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment," "Home Health Care," and "Hospice Care" in the "Covered Benefits" section.

Items and services that are not health care items and services

For example, the plan does not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services for the purpose of increasing academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming, except that this exclusion for "teaching play" does not apply to Services that are part of a behavioral health therapy treatment plan and covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Covered Benefits"
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses

- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Home Health Care," "Hospice Services," or "Rehabilitative and Habilitative Services" in the "Covered Benefits" section

Items and services to correct refractive defects of the eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

Massage therapy

Massage therapy, except that this exclusion does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Home Health Care," "Hospice Services," or "Rehabilitative and Habilitative Services" in the "Covered Benefits" section.

Oral nutrition

Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food.

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Covered Benefits" section
- Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Covered Benefits" section

Routine foot care items and services

Routine foot care items and services that are not Medically Necessary

Services not approved by the federal Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other Services that by law require federal Food and Drug Administration (FDA) approval to be sold in the U.S. but are not approved by the FDA. This exclusion applies to Services provided anywhere, even outside the U.S.

This exclusion does not apply to any of the following:

- Services covered under the "Emergency Services and Urgent Care" section that you receive outside the U.S.
- Experimental or investigational Services when an investigational application has been filed with the FDA and the manufacturer or other source makes the Services available to you or the plan through an FDA-authorized procedure, except that the plan does not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other

investigational treatment protocol

- Services covered under "Services in Connection with a Clinical Trial" in the "Covered Benefits" section

Services performed by unlicensed people

Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider.

This exclusion does not apply to Services covered under the “Behavioral Health Treatment for Pervasive Developmental Disorder or Autism” in the “Covered Benefits” section.

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services the plan would otherwise cover to treat complications of the noncovered Service. For example, if you have a noncovered cosmetic surgery, the plan would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and the plan would cover any Services that the plan would otherwise cover to treat that complication.

Travel and lodging expenses

Travel and lodging expenses, except for the following:

- In some situations if the Plan Provider refers you to a Non–Plan Provider, the plan may pay certain expenses that the plan preauthorize in accord with the plan’s travel and lodging guidelines.
- Reimbursement for travel and lodging expenses provided under “Bariatric Surgery” in the “Covered Benefits” section.