In this policy (the "Policy"), You, the insured person, will be referred to as "You" or "Your." Jefferson Health Plans is referred to as "We" or "Us" or "Our." The Policy will be in effect during the duration of Your eligible coverage with Us.

Your Premium might be increased upon the renewal date of this plan. In the event of a rate increase, We will provide written notice of the increase at least 60 days before the increase takes effect. Rate increases will only take effect after the Pennsylvania Department of Insurance has approved the change and will apply only at the beginning of a new plan year.

Health Partners Plans, Inc.
d.b.a. Jefferson Health Plans

(Heretoafter and for purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc.)

Jefferson Health Plans HMO
Description of Coverage

This HMO Subscriber Agreement sets forth a comprehensive program of inpatient and outpatient health care benefits.

Notice of Insured's Right to Examine Policy for Ten Days

If You are not satisfied, for any reason, with the terms of the Policy, You may return the Policy to Us within 10 days of receipt. We will then cancel Your coverage as of the original effective date and promptly refund any Premium You have paid. This Policy will then be null and void. If You wish to correspond with Us for this or any other reason, write:

Jefferson Health Plans
ATTN: Individual Services (ACA)
1101 Market Street, Suite 3000
Philadelphia, PA 19107

Include Your Jefferson Health Plans identification number with any correspondence. This number can be found on Your Jefferson Health Plans identification card (ID card). You can also call the number on the back of Your ID card for information.

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ!

This Policy was issued to You by Jefferson Health Plans (referred to herein as Jefferson Health Plans or "We" or "Us") based on the information You provided in Your application. If You know of any misstatement in Your application, You should advise Us immediately regarding the incorrect information; otherwise, Your Policy may not be a valid contract.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY AND WILL NOT DUPLICATE MEDICARE BENEFITS.

Guaranteed Renewable

This Policy is monthly medical coverage subject to continual payment by YOU as the Insured Person. Jefferson Health Plans will renew this Policy except for the specific events stated in the Policy. Coverage under this Policy is effective at 12:01 a.m. **Eastern time** on the effective date shown on the Policy's specification page.

THIS IS A NON-PARTICIPATING CONTRACT

Signed for Jefferson Health Plans by:
Krista Hoglund, ASA, MAAA, MBA
President

IMPORTANT NOTICES

Direct Access to Obstetricians and Gynecologists

You do not need Prior Authorization from Us or from any other person (including Your PCP in order to obtain access to obstetrical or gynecological care from a health care professional in Our network who is credentialed as an obstetrician or gynecologist. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit https://www.jeffersonhealthplans.com/individuals-families/ or contact Member Relations at the phone number listed on the back of Your ID card.

Selection of a Primary Care Physician

This plan requires the designation of a Primary Care Physician. Referrals are not required as a precondition for coverage of specialty care. When selecting a Primary Care Physician, You have the right to designate any Primary Care Physician who participates in the network and who is available to accept You or Your Family Members. For information on how to select a Primary Care Physician, and for a list of the participating Primary Care Physicians, visit https://www.jeffersonhealthplans.com/individuals-families/ or contact Customer Service at the phone number listed on the back of Your ID card.

For children, You may designate a pediatrician as the Primary Care Physician

Non Discrimination Rights

You have the right to receive health care services without discrimination:

- Based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including stereotypes and gender identity.
- For Medically Necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender.
- Based on an individual’s sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available.
- Related to gender transition if such denial or limitation results in discrimination against a transgender individual.

TABLE OF CONTENTS

Introduction

About This Policy

Your medical coverage is provided under a Policy issued by JEFFERSON HEALTH PLANS, INC. This Policy is a legal contract between You and Us.

The benefits of this Policy are provided only for those services that are Medically Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Physician prescribes or orders a service does not mean that the service is Medically Necessary or that the service is a Covered Service. Consult this Policy or call Us at the number shown on Your Jefferson Health Plans member ID card if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as “Medically Necessary” and “Covered Service”) that are defined in the section entitled “Definitions.” Before reading through this Policy, be sure that You understand the meanings of these words as they pertain to this Policy.

We provide coverage to You under this Policy based upon the answers submitted by You and Your family member(s) on Your signed individual application. In consideration for the payment of the premiums stated in this Policy, We will provide the services and benefits listed in this Policy to You and Your family member(s) covered under the Policy.

IF, WITHIN 3 YEARS AFTER THE EFFECTIVE DATE OF YOUR PARTICIPATION IN THE POLICY, WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED OR THAT YOU OR YOUR FAMILY MEMBER(S) KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND THIS COVERAGE AS OF THE ORIGINAL EFFECTIVE DATE. ADDITIONALLY, IF WITHIN 3 YEARS AFTER ADDING ADDITIONAL FAMILY MEMBER(S) (EXCLUDING NEWBORN CHILDREN ADDED WITHIN 31 DAYS AFTER BIRTH), WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED OR THAT YOU OR YOUR FAMILY MEMBER(S) KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND COVERAGE FOR THE ADDITIONAL FAMILY MEMBER(S) AS OF THE DATE HE OR SHE ORIGINALLY BECAME EFFECTIVE. IF WE RESCIND YOUR COVERAGE, WE WILL PROVIDE YOU WITH 30 DAYS ADVANCE NOTICE AND WE WILL REFUND ALL PREMIUMS YOU PAID FOR YOUR POLICY LESS THE AMOUNT OF ANY CLAIMS PAID BY US. RESCISSION OF YOUR COVERAGE WILL RESULT IN DENIAL OF ALL PENDING CLAIMS AND, IF CLAIM PAYMENTS EXCEED TOTAL PREMIUMS PAID, THEN CLAIMS PREVIOUSLY PAID BY US WILL BE RETROACTIVELY DENIED, OBLIGATING YOU TO PAY THE PROVIDER IN FULL FOR SERVICES RENDERED AT THE PROVIDER’S REGULAR BILLED RATE, NOT AT THE JEFFERSON HEALTH PLANS NEGOTIATED RATE.

Choice of Hospital and Physician

Nothing contained in this Policy restricts or interferes with an Insured Person's right to select the Hospital or Physician of their choice. However, non-Emergency Services from an Out-of-Network provider are not covered by this Policy.

THIS IS A HEALTH MAINTENANCE ORGANIZATION (HMO) POLICY

That means this Policy does not provide benefits for any services You receive from an Out-of-Network Provider except:

- Services for Stabilization and initial treatment of an Emergency Medical Condition, or
- Medically Necessary Covered services that are not available through an In-Network Provider.

In-Network Providers include Physicians, Hospitals, and Other Health Care Facilities. Check the provider directory, available at https://www.jeffersonhealthplans.com/individuals-families/ or call the number on Your ID card to determine if a provider is In-Network.

Choosing a Primary Care Physician (PCP)

A Primary Care Physician ("PCP") serves an important role in meeting health care needs by providing or arranging for medical care for each Insured Person. For this reason, when You enroll as an Insured Person, You will be required to select a PCP. Your PCP will provide Your regular medical care and assist in coordinating Your care. You may select Your PCP by calling the customer service phone number on Your ID card or by visiting Our website at:
https://www.jeffersonhealthplans.com/individuals-families/ If You do not select a PCP at enrollment, You will be assigned a PCP. You may change your PCP at any time. The PCP You select for Yourself may be different from the PCP You select for each of Your Family Member(s). You have the right to designate any PCP who participates in Our network for this Plan and is available to accept You or Your Family Members.

If You Need a Specialist

Your PCP is important to the coordination of Your care. While this Policy does not require referrals to visit specialists, if You need specialty care You are encouraged to work with Your PCP, who can coordinate Your care and assist You in selecting a specialist appropriate for Your care.

The referral system can be used to keep Your PCP involved in and apprised of all of Your health care needs. If You receive Covered Services from a specialist in the Plan's network without a referral, You will not be subject to a penalty, and the claims for those Covered Services will be processed according to the applicable In-Network level of benefits.

If Your Physician Leaves the Network

If Your provider or specialist ceases to be a participating physician, We will notify You in writing of his or her impending termination at least 30 days in advance of the date the provider leaves the network, when possible, and provide assistance in selecting a new provider or identifying a new specialist to continue providing Covered Services.

If You are receiving treatment from a Participating Provider at the time his or her Participating Provider agreement is terminated, for reasons other than medical incompetence or professional misconduct, You may be eligible for continued care with that provider.

Continuity of Care

If Your PCP or specialist ceases to be a participating physician, We will notify You. Under certain medical circumstances, We may continue to reimburse Covered Expenses from Your PCP or a specialist You've been seeing at the Participating Provider benefit level even though he or she is no longer affiliated with Our network. If You are undergoing an active course of treatment for an acute or chronic condition and continued treatment is Medically Necessary, You may be eligible to receive continuing care from the Non-Participating Provider for a specified time, subject to the treating provider's agreement. You may also be eligible to receive continuing care if You are in Your second or third trimester of pregnancy. In this case, continued care may be extended through Your delivery and include a period of postpartum care.

Such continuity of care must be approved in advance by Us, and Your physician must agree to accept Our reimbursement rate and to abide by Our policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider who ceases to be a Participating Provider will not be available, such as when the provider loses his/her license to practice or retires.

You may request continuity of care from Us after Your Participating Provider's termination from Our network; start by calling the toll-free number on Your ID card. In order to be eligible for coverage under this plan, continuity of care must be Medically Necessary and approved in advance by Us. Continuity of care will cease upon the earlier of:

- Successful transition of Your care to a Participating Provider; or
- Completion of Your treatment; or
- 90 days

Confined to a Hospital

If You are confined in a Hospital on the effective date of Your coverage, You must notify Us of such a hospitalization within two (2) days, or as soon as reasonably possible thereafter. When You are enrolled as an Insured Person, You agree to permit Jefferson Health Plans to assume direct coordination of Your health care. We reserve the right to transfer You to the care of a Participating Provider and/or participating Hospital if Jefferson Health Plans, in consultation with Your attending physician, determines that it is medically safe to do so.

If You are hospitalized on the effective date of coverage and You fail to notify Us of this hospitalization, refuse to permit Us to coordinate Your care, or refuse to be transferred to the care of a Participating Provider or participating Hospital, We will not be obligated to pay for any medical or Hospital expenses that are related to Your hospitalization following the first two (2) days after Your coverage begins.

Important Information Regarding Benefits

PRIOR AUTHORIZATION FOR INPATIENT SERVICES

Prior Authorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION to a Hospital or certain other facilities MAY RESULT IN A PENALTY OR DENIAL OF PAYMENT FOR THE SERVICES PROVIDED.

Prior Authorization can be obtained by You, Your family member(s) or the provider by calling the number on the back of Your ID card.

To verify Prior Authorization requirements for inpatient services, including which other types of facility admissions require Prior Authorization, You can:

- Call Us at the number on the back of Your ID card, or
- Check https://www.jeffersonhealthplans.com/individuals-families/ under "Coverage" then select "Medical."

Please note that emergency admissions will be reviewed post admission.

Inpatient Prior Authorization reviews whether admission to the Hospital and whether continued confinement in the Hospital are both Medically Necessary and eligible for coverage under the terms and conditions of this Policy.

PRIOR AUTHORIZATION FOR <u>OUTPATIENT</u> SERVICES

Prior Authorization is also required for certain outpatient procedures and services in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO CERTAIN ELECTIVE OUTPATIENT PROCEDURES AND SERVICES MAY RESULT IN A PENALTY OR DENIAL OF PAYMENT FOR THE SERVICES PROVIDED.

Prior Authorization can be obtained by You, Your family member(s) or the provider by calling the number on the back of Your ID card. Outpatient Prior Authorization should only be requested for non-emergency procedures or services, at least four working days (Monday through Friday, non-holiday) prior to having the procedure performed or the service rendered.

To verify Prior Authorization requirements for outpatient procedures and services, including which procedures and services require Prior Authorization, You can:

- Call Us at the number on the back of Your ID card, or
- Check https://www.jeffersonhealthplans.com/individuals-families/ under "Coverage" then select "Medical."

PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. Prior Authorization does not guarantee payment of benefits. Coverage is always subject to other requirements of this Policy, including limitations and exclusions, payment of Premium, and eligibility at the time care and services are provided.

Retrospective Review

If Prior Authorization was not performed, We may use retrospective review to determine if a scheduled or emergency admission or other service was Medically Necessary. In the event the services are determined to be Medically Necessary, benefits will be provided as described in this Policy subject any limitations and exclusions, payment of Premium and eligibility at the time care and services are provided. If it is determined that a service was not Medically Necessary, We will not cover any charges for that service.

PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS

Prior Authorization is required for certain prescription drugs and related supplies. **For complete, detailed information about prescription drug authorization procedures, exceptions, and Step Therapy, please refer to the section of this Policy titled "Prescription Drug Benefits."**

To verify Prior Authorization requirements for prescription drugs and related supplies, including which prescription drugs and related supplies require authorization, You can:

- Call Us at the number on the back of Your ID card, or

- Log on to https://www.jeffersonhealthplans.com/individuals-families/

NOTE REGARDING PRIOR AUTHORIZATION OF INPATIENT SERVICES, OUTPATIENT SERVICES AND PRESCRIPTION DRUGS

Some services or therapies may require You to use particular providers approved by Us for the particular service or therapy and will not be covered if You receive them from any other provider regardless of participation status.

BENEFIT SCHEDULE

Intentionally left blank. Benefits are located within the Outline of Coverage which begins on page

2025 PREVENTIVE BENEFIT SCHEDULE

This schedule is a reference tool for planning Your preventive care and lists items/services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended. In accordance with the PPACA, the schedule is reviewed and updated periodically based on the recommendations of the U.S. Preventive Services Task Force, Health Resources and Services Administration, U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, and other applicable laws and regulations. Accordingly, the content of this schedule is subject to change. Your specific needs for preventive services may vary according to Your personal risk factors. Your health care provider is always Your best resource for determining if You are at increased risk for a condition. Some services may require precertification/preapproval. If You have questions about this schedule, precertification/preapproval, or Your benefit coverage, please call Member Relations at the number on the back of Your ID card.

PREVENTIVE CARE SERVICES FOR ADULTS

SERVICES	COVERAGE LIMITS
Preventive exams Services that may be provided during the preventive exam include, but are not limited to the following: ▪ High blood pressure screening ▪ Behavioral counseling for skin cancer ▪ Obesity screening ▪ Unhealthy drug use screening	One exam annually for all adults
SCREENINGS	**COVERAGE LIMITS**
Abdominal aortic aneurysm (AAA) screening	Once in a lifetime for asymptomatic males aged 65 to 75 years with a history of smoking
Colorectal cancer screening	Adults aged 45 to 75 years using any of the following tests: ▪ Fecal occult blood testing: once a year ▪ Highly sensitive fecal immunochemical testing (FIT): once a year ▪ Flexible sigmoidoscopy: once every five years ▪ CT colonography: once every five years ▪ Stool DNA testing alone or combined with FIT: once every three years ▪ Colonoscopy: once every 10 years
Depression screening	Annually for all adults
Hepatitis B virus (HBV) screening	All asymptomatic adults at high risk for HBV infection
Hepatitis C virus (HCV) screening	All asymptomatic adults ages 18 to 79
High blood pressure screening	Adults aged 18 years or older with increased risk once a year; Adults aged 18 to 39 years with no other risk factors once every 3 to 5 years; Adults aged 40 years once a year
Human immunodeficiency virus (HIV) screening	All adults
Latent tuberculosis infection screening	Asymptomatic adults aged 19 years or older at increased risk for tuberculosis

Lipid disorder screening	Adults aged 40 years or older once every 5 years
Lung cancer screening	Adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years
Syphilis infection screening	All adults at increased risk for syphilis infection
Prediabetes and Type 2 Diabetes Mellitus Screening	Asymptomatic adults 35-70 years who are overweight or obese every 3 years
Unhealthy alcohol use screening and behavioral counseling interventions	Screening for all adults not diagnosed with alcohol abuse or dependence or not seeking treatment for alcohol abuse or dependence. Behavioral counseling in a primary care setting for individuals with a positive screening result
THERAPY AND COUNSELING	**COVERAGE LIMITS**
Behavioral counseling for prevention of sexually transmitted infections	All sexually active adults
Behavioral interventions for weight loss	Behavioral intervention for adults with a body mass index (BMI) of 30kg/m^2 or higher
Exercise interventions for the prevention of falls	Community-dwelling adults ages 65 years and older with an increased risk of falls
Intensive behavioral counseling interventions to promote a healthful diet and physical activities for cardiovascular disease prevention	Adults aged 18 years and older diagnosed as overweight or obese with known cardiovascular disease risk factors
Nutritional counseling for weight management	6 visits per year
Tobacco use counseling	All adults who use tobacco products
Work-up and follow-up services for pre-exposure prophylaxis for prevention of HIV	Adults at high risk for HIV infection
MEDICATIONS	**COVERAGE LIMITS**
Low dose aspirin	Adults aged 50 to 59 years for the primary prevention of cardiovascular disease and colorectal cancer
Pre-exposure prophylaxis for the prevention of HIV infection	Adults at high risk for HIV infection
Prescription bowel preparation	Adults aged 45 years and older when used in conjunction with a preventive colorectal cancer screening procedure (flexible sigmoidoscopy, colonoscopy, virtual colonoscopy)
Statin	Adults aged 40 to 75 with no history of cardiovascular disease, with one or more risk factors for cardiovascular disease and a 10-year cardiovascular disease event risk of greater than 10%
Tobacco cessation medication	All adults who use tobacco products

ADULT IMMUNIZATION SCHEDULE

Recommended Adult Immunization Schedule for ages 19 years or older

UNITED STATES 2025

Vaccines in the Adult Immunization Schedule*

Vaccine	Abbreviation(s)	Trade name(s)
COVID-19 vaccine	1vCOV-mRNA	Comirnaty/Pfizer-BioNTech COVID-19 Vaccine Spikevax/Moderna COVID-19 Vaccine
	1vCOV-aPS	Novavax COVID-19 Vaccine
Haemophilus influenzae type b vaccine	Hib	ActHIB, Hiberix, PedvaxHIB
Hepatitis A vaccine	HepA	Havrix, Vaqta
Hepatitis A and hepatitis B vaccine	HepA-HepB	Twinrix
Hepatitis B vaccine	HepB	Engerix-B, Heplisav-B, PreHevbrio, Recombivax HB
Human papillomavirus vaccine	HPV	Gardasil 9
Influenza vaccine (inactivated, egg-based)	IIV3	Multiple
	aIIV3	Fluad
	HD-IIV3	Fluzone High-Dose
Influenza vaccine (inactivated, cell-culture)	ccIIV3	Flucelvax
Influenza vaccine (recombinant)	RIV3	Flublok
Influenza vaccine (live, attenuated)	LAIV3	FluMist
Measles, mumps, and rubella vaccine	MMR	M-M-R II, Priorix
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-CRM	Menveo
	MenACWY-TT	MenQuadfi
Meningococcal serogroup B vaccine	MenB-4C	Bexsero
	MenB-FHbp	Trumenba
Meningococcal serogroup A, B, C, W, Y vaccine	MenACWY-TT/ MenB-FHbp	Penbraya
Mpox vaccine	Mpox	Jynneos
Pneumococcal conjugate vaccine	PCV15	Vaxneuvance
	PCV20	Prevnar 20
	PCV21	Capvaxive
Pneumococcal polysaccharide vaccine	PPSV23	Pneumovax 23
Poliovirus vaccine (inactivated)	IPV	Ipol
Respiratory syncytial virus vaccine	RSV	Abrysvo, Arexvy, mResvia
Tetanus and diphtheria vaccine	Td	Tenivac
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Adacel, Boostrix
Varicella vaccine	VAR	Varivax
Zoster vaccine, recombinant	RZV	Shingrix

*Administer recommended vaccines if vaccination history is incomplete or unknown.
Do not restart or add doses to vaccine series if there are extended intervals between doses.
The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

11/21/2024

How to use the adult immunization schedule

1. Determine recommended vaccinations by age **(Table 1)**
2. Assess need for additional recommended vaccinations by medical condition or other indication **(Table 2)**
3. Review vaccine types, dosing frequencies and intervals, and considerations for special situations **(Notes)**
4. Review contraindications and precautions for vaccine types **(Appendix)**
5. Review new or updated ACIP guidance **(Addendum)**

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American College of Physicians (www.acponline.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Associates (www.aapa.org), American Pharmacists Association (www.pharmacist.com), and Society for Healthcare Epidemiology of America (www.shea-online.org).

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to the local or state health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System at www.vaers.hhs.gov or 800-822-7967

Questions or comments

Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays.

Download the CDC Vaccine Schedules app for providers at www.cdc.gov/vaccines/hcp/imz-schedules/app.html.

Helpful information

- Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/acip-recs/hcp/vaccine-specific/
- ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/acip/vaccine-recommendations/shared-clinical-decision-making.html
- *General Best Practice Guidelines for Immunization* www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/index.html
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): www.cdc.gov/surv-manual/php/index.html

U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

<u>ADULT PREVENTIVE SCHEDULE, CONTINUED.</u>

Table 1 Recommended Adult Immunization Schedule by Age Group, United States, 2025

Vaccine	19–26 years	27–49 years	50–64 years	≥65 years
COVID-19	1 or more doses of 2024–2025 vaccine (See Notes)			2 or more doses of 2024-2025 vaccine (See Notes)
Influenza inactivated (IIV3, ccIIV3) **Influenza recombinant** (RIV3)	1 dose annually			1 dose annually (HD-IIV3, RIV3, or aIIV3 preferred)
Influenza inactivated (aIIV3; HD-IIV3) **Influenza recombinant** (RIV3)	Solid organ transplant (See Notes)			
Influenza live, attenuated (LAIV3)	1 dose annually		—	—
Respiratory syncytial virus (RSV)	Seasonal administration during pregnancy (See Notes)		— / 60 through 74 years (See Notes)	≥75 years
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap each pregnancy; 1 dose Td/Tdap for wound management (See Notes) 1 dose Tdap, then Td or Tdap booster every 10 years			
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)			For health care personnel (See Notes)
Varicella (VAR)	2 doses (if born in 1980 or later)		2 doses	
Zoster recombinant (RZV)	2 doses for immunocompromising conditions (See Notes)		2 doses	
Human papillomavirus (HPV)	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years	—	—
Pneumococcal (PCV15, PCV20, PCV21, PPSV23)			See Notes	See Notes
Hepatitis A (HepA)	2, 3, or 4 doses depending on vaccine			
Hepatitis B (HepB)	2, 3, or 4 doses depending on vaccine or condition			
Meningococcal A, C, W, Y (MenACWY)	1 or 2 doses depending on indication (See Notes for booster recommendations)			
Meningococcal B (MenB)	19 through 23 years 2 or 3 doses depending on vaccine and indication (See Notes for booster recommendations)			
***Haemophilus influenzae* type b** (Hib)	1 or 3 doses depending on indication			
Mpox	2 doses			
Inactivated poliovirus (IPV)	Complete 3-dose series if incompletely vaccinated. Self-report of previous doses acceptable (See Notes)			

Yellow: Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of immunity
Purple: Recommended vaccination for adults with an additional risk factor or another indication
Blue: Recommended vaccination based on shared clinical decision-making
Gray: No Guidance/ Not Applicable

Notes Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

For vaccination recommendations for persons ages 18 years or younger, see the Recommended Child and Adolescent Immunization Schedule, 2025: www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html

Additional Information

- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3-2, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccination requirements and recommendations is available at www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All vaccines included in the adult immunization schedule except PPSV23, RSV, RZV, Mpox, and COVID-19 vaccines are covered by the National Vaccine Injury Compensation Program (VICP). Mpox and COVID-19 vaccines are covered by the Countermeasures Injury Compensation Program (CICP). For more information, see www.hrsa.gov/vaccinecompensation or www.hrsa.gov/cicp.

COVID-19 vaccination

Routine vaccination

Age 19–64 years

- **Unvaccinated:**
  - 1 dose 2024–25 Moderna or Pfizer-BioNTech
  - 2 doses 2024–25 Novavax at 0, 3–8 weeks
- **Previously vaccinated before 2024–25 vaccine with:**
  - **1 or more doses Moderna or Pfizer-BioNTech:** 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose.
  - **1 dose Novavax:** 1 dose 2024–25 Novavax 3–8 weeks after most recent dose. If more than 8 weeks after most recent dose, administer 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech.
  - **2 or more doses Novavax:** 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose.
  - **1 or more doses Janssen:** 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech.

Age 65 years and older

- **Unvaccinated:** follow recommendations above for unvaccinated persons ages 19–64 years **and** administer dose 2 of 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months).
- **Previously vaccinated before 2024–25 vaccine:** follow recommendations above for previously vaccinated persons ages 19–64 years **and** administer dose 2 of 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months).

Special situations

Persons who are moderately or severely immunocompromised. Use vaccine from the same manufacturer for all doses in the initial vaccination series.

- **Unvaccinated:**
  - 4 doses (**3-dose initial series 2024–25 Moderna** at 0, 4 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses.*
  - 4 doses (**3-dose initial series 2024–25 Pfizer-BioNTech** at 0, 3 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses.*
  - 3 doses (**2-dose initial series 2024–25 Novavax** at 0, 3 weeks, followed by 1 dose Moderna or Novavax or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses.*
- **Incomplete initial vaccination series before 2024–25 vaccine:**
  - **Previous vaccination with Moderna**
    - **1 dose Moderna:** complete initial series with 2 doses 2024–25 Moderna at least 4 weeks apart (administer dose 1 4 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses.*
    - **2 doses Moderna:** complete initial series with 1 dose 2024–25 Moderna at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses.*

Notes Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

COVID-19 vaccination - *continued*

- **Previous vaccination with Pfizer-BioNTech**
  - **1 dose Pfizer-BioNTech:** complete initial series with 2 doses 2024–25 Pfizer-BioNTech at least 4 weeks apart (administer dose 1 3 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses.*
  - **2 doses Pfizer-BioNTech:** complete initial series with 1 dose 2024–25 Pfizer-BioNTech at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses.*
- **Previous vaccination with Novavax**
  - **1 dose Novavax:** complete initial series with 1 dose 2024–25 Novavax at least 3 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses.*

• **Completed the initial vaccination series before 2024–25 vaccine with:**
- **3 or more doses Moderna or 3 or more doses Pfizer-BioNTech:** 2 doses 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses.*
- **2 or more doses Novavax:** 2 doses 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses.*

***Additional doses of 2024–25 COVID-19 vaccine for moderately or severely immunocompromised:** based on shared clinical decision-making and administered at least 2 months after the most recent dose (see Table 2 at www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#table-02.). For description of moderate and severe immunocompromising conditions and treatment, see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#immunocompromising-conditions-treatment.

Unvaccinated persons have never received any COVID-19 vaccine doses. There is no preferential recommendation for the use of one COVID-19 vaccine over another when more than one recommended age-appropriate vaccine is available. Administer an age-appropriate COVID-19 vaccine product for each dose.

For information about interchangeability of COVID-19 vaccines, see wcms-wp.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#Interchangeability.

Current COVID-19 schedule and dosage formulation available at www.cdc.gov/covidschedule. For more information on Emergency Use Authorization (EUA) indications for COVID-19 vaccines, see www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines.

Haemophilus influenzae type b vaccination

Special situations

- **Anatomical or functional asplenia (including sickle cell disease):** 1 dose if previously did not receive Hib vaccine
  - **Elective splenectomy:** 1 dose preferably at least 14 days before splenectomy
- **Hematopoietic stem cell transplant (HSCT):** 3-dose series 4 weeks apart starting 6–12 months after successful transplant, regardless of Hib vaccination history

Hepatitis A vaccination

Routine vaccination

- **Any person who is not fully vaccinated and requests vaccination** (identification of risk factor not required): complete 2-dose series HepA (Havrix 6–12 months apart or Vaqta 6–18 months apart [minimum interval: 6 months]) or 3-dose series HepA–HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2 = 4 weeks; dose 2 to dose 3 = 5 months])

Special situations

- **Any person who is not fully vaccinated and who is at risk for hepatitis A virus infection or severe disease from hepatitis A virus infection:** complete 2-dose series HepA or 3-dose series HepA–HepB as above. Risk factors include:
  - **Chronic liver disease** including persons with hepatitis B, hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase (ALT) or aspartate aminotransferase (AST) level greater than twice the upper limit of normal.
  - **HIV infection**
  - **Men who have sex with men**
  - **Injection or noninjection drug use**
  - **Persons experiencing homelessness**
  - **Work with hepatitis A virus** in research laboratory or with nonhuman primates with hepatitis A virus infection
  - **Travel in countries with high or intermediate endemic hepatitis A:** HepA–HepB (Twinrix) may be administered on an accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months.
  - **Close, personal contact with international adoptee** (e.g., household or regular babysitting) in first 60 days after arrival from country with high or intermediate endemic hepatitis A: dose 1 as soon as adoption is planned; preferably at least 2 weeks before adoptee's arrival.

ADULT PREVENTIVE SCHEDULE, CONTINUED.

Notes Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

Hepatitis A vaccination - *continued*

- **Pregnancy** if at risk for infection or severe outcome from infection during pregnancy
- **Settings for exposure,** including health care setting serving persons who use injection or noninjection drugs, or group homes and nonresidential day care facilities for developmentally disabled persons (individual risk factor screening not required)

WHITE SPACE INTENTIONALLY LEFT BLANK

Hepatitis B vaccination

Routine vaccination

- **Age 19 through 59 years:** complete a 2- or 3- or 4-dose series
  - 2-dose series only applies when 2 doses of Heplisav–B are used at least 4 weeks apart
  - 3-dose series Engerix–B, PreHevbrio*, or Recombivax HB at 0, 1, 6 months (minimum intervals: dose 1 to dose 2 = 4 weeks; dose 2 to dose 3 = 8 weeks; dose 1 to dose 3 = 16 weeks)
  - 3-dose series HepA–HepB (Twinrix) at 0, 1, 6 months (minimum intervals: dose 1 to dose 2 = 4 weeks; dose 2 to dose 3 = 5 months)
  - 4-dose series HepA–HepB (Twinrix) accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months

***Note:** PreHevbrio is not recommended in pregnancy due to lack of safety data in pregnant persons.

- **Age 60 years or older without** known risk factors for hepatitis B virus infection **may** receive a HepB vaccine series.
- **Age 60 years or older with** known risk factors for hepatitis B virus infection **should** receive a HepB vaccine series.
- **Any adult age 60 years of age or older** who requests HepB vaccination **should** receive a HepB vaccine series.
  - **Risk factors for hepatitis B virus infection include:**
    - **Chronic liver disease** including persons with hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase (ALT) or aspartate aminotransferase (AST) level greater than twice the upper limit of normal.
    - **HIV infection**
    - **Sexual exposure risk** e.g., sex partners of hepatitis B surface antigen (HBsAg)–positive persons, sexually active persons not in mutually monogamous relationships, persons seeking evaluation or treatment for a sexually transmitted infection, men who have sex with men
    - **Current or recent injection drug use**
    - **Percutaneous or mucosal risk for exposure to blood** e.g., household contacts of HBsAg–positive persons, residents and staff of facilities for developmentally disabled persons, health care and public safety personnel with reasonably anticipated risk for exposure to blood or blood–contaminated body fluids, persons on maintenance dialysis (including in–center or home hemodialysis and peritoneal dialysis), persons who are predialysis, and patients with diabetes**
    - **Incarceration**
    - **Travel in countries with high or intermediate endemic hepatitis B**

****Age 60 years or older with diabetes:** Based on shared clinical decision making, 2-, 3-, or 4-dose series as above.

Special situations

- **Patients on dialysis:** complete a 3- or 4-dose series
  - 3-dose series Recombivax HB at 0, 1, 6 months (Note: Use Dialysis Formulation 1 mL = 40 mcg)
  - 4-dose series Engerix–B at 0, 1, 2, and 6 months (Note: Use 2 mL dose instead of the normal adult dose of 1 mL)
- **Age 20 years or older with an immunocompromising condition:** complete a 2- or 3- or 4-dose series.
  - 3-dose series Recombivax HB at 0,1, 6 months (Note: Use Dialysis Formulation 1ml = 40 mcg)
  - 4-dose series Engerix–B at 0,1,2, and 6 months (Note: Use 2mL dose instead of the normal adult dose of 1mL)
  - 2-doses series Heplisav–B at 0, 1 months
  - 3-dose series PreHevbrio* at 0,1, 6 months

Notes Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

Human papillomavirus vaccination

Routine vaccination

- **All persons through age 26 years:** complete 2– or 3-dose series depending on age at initial vaccination or condition.
  - **Age 9–14 years at initial vaccination and received 1 dose or 2 doses less than 5 months apart:** 1 additional dose
  - **Age 9–14 years at initial vaccination and received 2 doses at least 5 months apart:** HPV vaccination series complete, no additional dose needed
  - **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2 = 4 weeks; dose 2 to dose 3 = 12 weeks; dose 1 to dose 3 = 5 months; repeat dose if administered too soon)
- No additional dose recommended when any HPV vaccine series of any valency has been completed using the recommended dosing intervals.

Shared clinical decision–making

- **Adults age 27–45 years:** Based on shared clinical decision–making, complete a 2-dose series (if initiated age 9–14 years) or 3-dose series (if initiated ≥15 years).

For additional information on shared clinical decision–making for HPV; see www.cdc.gov/vaccines/hcp/admin/downloads/isd–job–aid–scdm–hpv–shared–clinical–decision–making–hpv.pdf

Special situations

- **Age ranges recommended above for routine and catch–up vaccination or shared clinical decision–making also apply in special situations**
  - **Immunocompromising conditions, including HIV infection**: complete 3-dose series, even for those who initiate vaccination at age 9 through 14 years.
  - **Pregnancy**: Pregnancy testing is not needed before vaccination. HPV vaccination is not recommended until after pregnancy. No intervention needed if inadvertently vaccinated while pregnant.

Influenza vaccination

Routine vaccination

- **Age 19 years or older:** 1 dose any influenza vaccine appropriate for age and health status annually
  - **Solid organ transplant recipients aged 19 through 64 years receiving immunosuppressive medications:** HD–IIV3 and aIIV3 are acceptable options. No preference over other age–appropriate IIV3 or RIV3.
  - **Age 65 years or older:** Any one of HD-IIV3, RIV3, or aIIV3 is preferred. If none of these three vaccines is available, then any other age–appropriate influenza vaccine should be used.
- For the 2024–25 season, see www.cdc.gov/mmwr/volumes/73/rr/rr7305a1.htm
- For the 2025–26 season, see the 2025–26 ACIP influenza vaccine recommendations.

Special situations

- **Close contacts (e.g., caregivers, healthcare workers) of severely immunosuppressed persons who require a protected environment:** should not receive LAIV3. If LAIV3 is given, they should avoid contact with/caring for such immunosuppressed persons for 7 days after vaccination.

Note: Persons with an egg allergy can receive any influenza vaccine (egg-based or non–egg based) appropriate for age and health status.

WHITE SPACE INTENTIONALLY LEFT BLANK

Measles, mumps, and rubella vaccination

Routine vaccination

- **No evidence of immunity to measles, mumps, or rubella:** 1 dose
  - **Evidence of immunity:** Born before 1957 (except for health care personnel, see below), documentation of receipt of MMR vaccine, laboratory evidence of immunity or disease (diagnosis of disease without laboratory confirmation is not evidence of immunity)

Special situations

- **Pregnancy with no evidence of immunity to rubella:** MMR contraindicated during pregnancy; after pregnancy (before discharge from health care facility): 1 dose
- **Nonpregnant persons of childbearing age with no evidence of immunity to rubella:** 1 dose
- **HIV infection with CD4 percentages ≥15% and CD4 count ≥200 cells/mm^3 for at least 6 months and no evidence of immunity to measles, mumps, or rubella:** complete 2-dose series at least 4 weeks apart; MMR contraindicated for HIV infection with CD4 percentage <15% or CD4 count <200 cells/mm^3
- **Severe immunocompromising conditions:** MMR contraindicated
- **Students in postsecondary educational institutions, international travelers, and household or close, personal contacts of immunocompromised persons with no evidence of immunity to measles, mumps, or rubella:** complete 2-dose series at least 4 weeks apart if previously did not receive any doses of MMR or 1 dose if previously received 1 dose MMR
- **In mumps outbreak settings,** for information about additional doses of MMR (including 3rd dose of MMR), see www.cdc.gov/mmwr/volumes/67/wr/mm6701a7.htm

ADULT PREVENTIVE SCHEDULE, CONTINUED.

Notes Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

Measles, mumps, and rubella vaccination - *continued*

- **Health care personnel:**
  - **Born before 1957 with no evidence of immunity to measles, mumps, or rubella:** Consider 2-dose series at least 4 weeks apart for protection against measles or mumps or 1 dose for protection against rubella.
  - **Born in 1957 or later with no evidence of immunity to measles, mumps, or rubella:** complete 2-dose series at least 4 weeks apart for protection against measles or mumps or at least 1 dose for protection against rubella.

WHITE SPACE INTENTIONALLY LEFT BLANK

Meningococcal vaccination

Special situations for MenACWY

- **Anatomical or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:** 2-dose primary series Menveo or MenQuadfi at least 8 weeks apart; 1 booster dose 5 years after primary series and every 5 years if risk remains
- **Travel in countries with hyperendemic or epidemic meningococcal disease, or for microbiologists routinely exposed to *Neisseria meningitidis*:** 1 dose Menveo or MenQuadfi; 1 booster dose 5 years after primary series and every 5 years if risk remains
- **First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:** 1 dose Menveo or MenQuadfi

For MenACWY recommendations **in outbreak setting** (e.g., in community or organizational settings, or among men who have sex with men) and **additional meningococcal vaccination** information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

Shared clinical decision-making for MenB

- **Adolescents and young adults age 16–23 years (age 16–18 years preferred)* not at increased risk for meningococcal disease:** based on shared clinical decision-making
  - **Bexsero or Trumenba (use same brand for all doses):** 2-dose series at least 6 months apart (if dose 2 is administered earlier than 6 months, administer dose 3 at least 4 months after dose 2)

*To optimize rapid protection (e.g., for students starting college in less than 6 months), a 3-dose series (0, 1–2, 6 months) may be administered.

For additional information on shared clinical decision-making for MenB, see www.cdc.gov/vaccines/hcp/admin/downloads/isd-job-aid-scdm-mening-b-shared-clinical-decision-making.pdf

Special situations for MenB

- **Anatomical or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use, or microbiologists routinely exposed to *Neisseria meningitidis*.**
  - **Bexsero or Trumenba (use same brand for all doses including booster doses):** 3-dose primary series at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed; if dose 3 is administered earlier than 4 months after dose 2, a 4th dose should be administered at least 4 months after dose 3).
  - **Booster doses:** 1 booster dose one year after primary series and every 2–3 years if risk remains
- **Pregnancy:** Delay MenB until after pregnancy due to lack of safety data in pregnant persons. May administer if at increased risk and vaccination benefits outweigh potential risks.

For MenB recommendations **in outbreak setting** (e.g., in community or organizational settings, or among men who have sex with men) and **additional meningococcal vaccination** information, see ww.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Note: MenB vaccines may be administered simultaneously with MenACWY vaccines if indicated, but at a different anatomic site, if feasible.

Adults may receive a single dose of Penbraya (MenACWY-TT/MenB-FHbp) as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day. For adults not at increased risk, if Penbraya is used for dose 1 MenB, then MenB-FHbp (Trumenba) should be administered for dose 2 MenB. For adults at increased risk of meningococcal disease, Penbraya may be used for additional MenACWY and MenB doses (including booster doses) if both would be given on the same clinic day **and** at least 6 months have elapsed since most recent Penbraya dose.

ADULT PREVENTIVE SCHEDULE, CONTINUED.

Notes Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

Mpox vaccination

Special situations

- **Any person at risk for mpox infection:** complete 2-dose series, 28 days apart.

  Risk factors for mpox infection include:
  - Persons who are gay or bisexual, and other MSM, transgender or nonbinary people who in the past 6 months have had:
    - A new diagnosis of at least 1 sexually transmitted disease
    - More than 1 sex partner
    - Sex at a commercial sex venue
    - Sex in association with a large public event in a geographic area where mpox transmission is occurring
  - Persons who are sexual partners of the persons described above
  - Persons who anticipate experiencing any of the situations described above
- **Pregnancy:** There is currently no ACIP recommendation for Jynneos use in pregnancy due to lack of safety data in pregnant persons. Pregnant persons with any risk factor described above may receive Jynneos.
- **Health care personnel:** Vaccination to protect against occupational risk in healthcare settings is not routinely recommended.

  For detailed information, see www.cdc.gov/mpox/hcp/vaccine-considerations/vaccination-overview.html.

Pneumococcal vaccination

Routine vaccination

- **Age 50 years or older who have:**
  - **Not previously received a dose of PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown:** 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21
    - If PCV15 is used, administer 1 dose PPSV23 at least 1 year after the PCV15 dose (may use minimum interval of 8 weeks for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak).
  - **Previously received only PCV7:** follow the recommendation above.
  - **Previously received only PCV13:** 1 dose PCV20 or 1 dose PCV21 at least 1 year after the last PCV13 dose
  - **Previously received only PPSV23:** 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21, at least 1 year after the last PPSV23 dose.
    - If PCV15 is used, no additional PPSV23 doses are recommended.
  - **Previously received both PCV13 and PPSV23 but NO PPSV23 was received at age 65 years or older:** 1 dose PCV20 or 1 dose PCV21 at least 5 years after the last pneumococcal vaccine dose.
  - **Previously received both PCV13 and PPSV23, AND PPSV23 was received at age 65 years or older:** Based on shared clinical decision–making, 1 dose of PCV20 or 1 dose of PCV21 at least 5 years after the last pneumococcal vaccine dose.

WHITE SPACE
INTENTIONALLY
LEFT BLANK

Special situations

- **Age 19–49 years with certain underlying medical conditions or other risk factors** who have:**
  - **Not previously received a PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown:** 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21
    - If PCV15 is used, administer 1 dose PPSV23 at least 1 year after the PCV15 dose (may use minimum interval of 8 weeks for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak).
  - **Previously received only PCV7:** follow the recommendation above.
  - **Previously received only PCV13:** 1 dose PCV20 or 1 dose PCV21 at least 1 year after the last PCV13 dose
  - **Previously received only PPSV23:** 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21, at least 1 year after the last PPSV23 dose.
    - If PCV15 is used, no additional PPSV23 doses are recommended.
  - **Previously received PCV13 and 1 dose of PPSV23:** 1 dose PCV20 or 1 dose PCV21 at least 5 years after the last pneumococcal vaccine dose.

Adults aged 19 years and older who have received PCV20 or PCV21: no additional pneumococcal vaccine dose recommended.

Pregnancy: no recommendation for PCV or PPSV23 due to limited data. Summary of existing data on pneumococcal vaccination during pregnancy can be found at www.cdc.gov/mmwr/volumes/72/rr/rr7203a1.htm.

Notes Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

Pneumococcal vaccination - *continued*

PPSV23 not available: adults aged 19 years or older who received PCV15 but have not yet completed PPSV23 series, can complete the series with either 1 dose of PCV20 or 1 dose of PCV21 if they no longer have access to PPSV23.

For guidance on determining which pneumococcal vaccines a patient needs and when, please refer to the mobile app which can be downloaded here: www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/app.html.

***Note:** Immunocompromising conditions include chronic renal failure, nephrotic syndrome, immunodeficiencies, iatrogenic immunosuppression, generalized malignancy, HIV infection, Hodgkin disease, leukemia, lymphoma, multiple myeloma, solid organ transplant, congenital or acquired asplenia, or sickle cell disease or other hemoglobinopathies.

****Note:** Underlying medical conditions or other risk factors include alcoholism, chronic heart/liver/lung disease, chronic renal failure, cigarette smoking, cochlear implant, congenital or acquired asplenia, CSF leak, diabetes mellitus, generalized malignancy, HIV infection, Hodgkin disease, immunodeficiencies, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, solid organ transplant, or sickle cell disease or other hemoglobinopathies.

Poliovirus vaccination

Routine vaccination

- **Adults known or suspected to be unvaccinated or incompletely vaccinated:** administer remaining doses (1, 2, or 3 IPV doses) to complete a 3-dose primary series.* Unless there are specific reasons to believe they were not vaccinated, most adults who were born and raised in the United States can assume they were vaccinated against polio as children.

Special situations

- **Adults at increased risk for exposure to poliovirus who completed primary series*:** may administer one lifetime IPV booster.

***Note:** Complete primary series consists of at least 3 doses of IPV or trivalent oral poliovirus vaccine (tOPV) in any combination.

For detailed information, see www.cdc.gov/vaccines/vpd/polio/hcp/recommendations.html

WHITE SPACE INTENTIONALLY LEFT BLANK

Respiratory syncytial virus vaccination

Routine vaccination

- **Pregnant persons of any age:**
  - **Pregnant at 32 weeks 0 days through 36 weeks and 6 days gestation from September through January in most of the continental United States*:** 1 dose **Abrysvo**. Administer RSV vaccine regardless of previous RSV infection.
  - Either maternal RSV vaccination with Abrysvo or infant immunization with nirsevimab (RSV monoclonal antibody) is recommended to prevent severe respiratory syncytial virus disease in infants.
  - **All other pregnant persons:** RSV vaccine not recommended
  - **Subsequent pregnancies:** additional doses not recommended. No data are available to inform whether additional doses are needed in subsequent pregnancies. Infants born to pregnant persons who received RSV vaccine during a previous pregnancy should receive nirsevimab.

***Note:** Providers in jurisdictions with RSV seasonality that differs from most of the continental United States (e.g., Alaska, jurisdictions with tropical climate) should follow guidance from public health authorities on timing of administration. Refer to the 2025 Child and Adolescent Immunization Schedule for considerations regarding nirsevimab administration to infants.

Age 75 years or older

- **Unvaccinated:** 1 dose (Arexvy or Abrysvo or mResvia). Additional doses not recommended
- **Previously vaccinated:** additional doses not recommended. No data are available to inform whether additional doses are needed.

ADULT PREVENTIVE SCHEDULE, CONTINUED.

Notes Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

Respiratory syncytial virus vaccination - *continued*

Special situations

- **Age 60–74 years:**
  - **Unvaccinated and at increased risk of severe RSV disease**:** 1 dose (Arexvy or Abrysvo or mResvia). Additional doses not recommended.
  - **Previously vaccinated:** additional doses not recommended. No data are available to inform whether additional doses are needed.

Persons 60 years and older can get RSV vaccine at any time but it is best to administer in late summer and early fall before RSV spreads in communities—ideally August through October in most of continental United States. For further guidance, see www.cdc.gov/mmwr/volumes/73/wr/mm7332e1.htm.

****Note: *People can self–attest to the presence of a risk factor.* The following medical and other conditions increase the risk of severe RSV disease:**

- Chronic cardiovascular disease e.g., heart failure, coronary artery disease, congenital heart disease. Excludes isolated hypertension.
- Chronic lung or respiratory disease e.g., chronic obstructive pulmonary disease, emphysema, asthma, interstitial lung disease, cystic fibrosis
- End stage renal disease or dependence on hemodialysis or other renal replacement therapy
- Diabetes mellitus complicated by chronic kidney disease, neuropathy, retinopathy, or other end–organ damage
- Diabetes mellitus requiring treatment with insulin or sodium–glucose cotransporter 2 (SGLT2) inhibitor
- Neurologic or neuromuscular conditions causing impaired airway clearance or respiratory muscle weakness e.g., post–stroke dysphagia, amyotrophic lateral sclerosis, muscular dystrophy. Excludes history of stroke without impaired airway clearance.
- Chronic liver disease e.g., cirrhosis
- Chronic hematologic conditions e.g., sickle cell disease, thalassemia
- Severe obesity (body mass index ≥ 40 kg/m2)
- Moderate or severe immune compromise
- Residence in a nursing home
- Other chronic medical conditions or risk factors that a health care provider determines would increase the risk of severe disease due to viral respiratory infection e.g., frailty, concern for presence of undiagnosed chronic medical conditions, residence in a remote or rural community where escalation of medical care is challenging.

WHITE SPACE INTENTIONALLY LEFT BLANK

Tetanus, diphtheria, and pertussis vaccination

Routine vaccination

- **Completed primary series and received at least 1 dose Tdap at age 10 years or older:** Td or Tdap every 10 years thereafter
- **Completed primary series and did NOT receive Tdap at age 10 years or older:** 1 dose Tdap, then Td or Tdap every 10 years thereafter
- **Unvaccinated or incomplete primary vaccination series for tetanus, diphtheria, or pertussis:** administer remaining doses (1, 2, or 3 doses) to complete 3-dose primary series. 1 dose Tdap followed by 1 dose Td or Tdap at least 4 weeks later, and a third dose of Td or Tdap 6–12 months later (Tdap is preferred as first dose and can be substituted for any Td dose), then Td or Tdap every 10 years thereafter.

Special situations

- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- **Wound management:** Persons with 3 or more doses of tetanus–toxoid–containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus–toxoid–containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus–toxoid–containing vaccine. Tdap is preferred for persons who have not previously received Tdap or whose Tdap history is unknown. If a tetanus–toxoid–containing vaccine is indicated for a pregnant woman, use Tdap. For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm

ADULT PREVENTIVE SCHEDULE, CONTINUED.

Notes Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

Varicella vaccination

Routine vaccination

- **No evidence of immunity to varicella:** 2-dose series 4–8 weeks apart if previously did not receive varicella–containing vaccine (VAR or MMRV [measles–mumps–rubella–varicella vaccine] for children); if previously received 1 dose varicella–containing vaccine, 1 dose at least 4 weeks after first dose.
  - **Evidence of immunity:** U.S.–born before 1980 (except for pregnant persons and health care personnel [see below]), documentation of 2 doses varicella–containing vaccine at least 4 weeks apart, diagnosis or verification of history of varicella or herpes zoster by a health care provider, laboratory evidence of immunity or disease.

Special situations

- **Pregnancy with no evidence of immunity to varicella:** VAR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose if previously received 1 dose varicella–containing vaccine or dose 1 of 2-dose series (dose 2: 4–8 weeks later) if previously did not receive any varicella–containing vaccine, regardless of whether U.S.–born before 1980.
- **Health care personnel with no evidence of immunity to varicella:** 1 dose if previously received 1 dose varicella–containing vaccine; 2-dose series 4–8 weeks apart if previously did not receive any varicella–containing vaccine, regardless of whether U.S.–born before 1980.
- **HIV infection with CD4 percentages ≥15% and CD4 count ≥200 cells/mm³ with no evidence of immunity:** Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 percentage <15% or CD4 count <200 cells/mm³.
- **Severe immunocompromising conditions:** VAR contraindicated

Zoster vaccination

Routine vaccination

- **Age 50 years or older*:** 2-dose series recombinant zoster vaccine (RZV, Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon), regardless of previous herpes zoster or history of zoster vaccine live (ZVL, Zostavax) vaccination.

*__Note:__ Serologic evidence of prior varicella is not necessary for zoster vaccination. However, if serologic evidence of varicella susceptibility becomes available, providers should follow ACIP guidelines for varicella vaccination first. RZV is not indicated for the prevention of varicella, and there are limited data on the use of RZV in persons without a history of varicella or varicella vaccination.

Special situations

- **Pregnancy:** There is currently no ACIP recommendation for RZV use in pregnancy. Consider delaying RZV until after pregnancy.
- **Immunocompromising conditions (including persons with HIV regardless of CD4 count)**:** 2-dose series recombinant zoster vaccine (RZV, Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon). For detailed information, see www.cdc.gov/shingles/hcp/vaccine–considerations/immunocompromised–adults.html

**__Note:__ If there is no documented history of varicella, varicella vaccination, or herpes zoster, providers should refer to the clinical considerations for use of RZV in immunocompromised adults aged ≥19 years and the ACIP varicella vaccine recommendations for further guidance: www.cdc.gov/mmwr/volumes/71/wr/mm7103a2.htm

WHITE SPACE INTENTIONALLY LEFT BLANK

PREVENTIVE CARE SERVICES FOR FEMALES, INCLUDING PREGNANT FEMALES

VISITS	COVERAGE LIMITS
Prenatal care visits Services that may be provided during the prenatal care visits include, but are not limited to the following: ▪ Preeclampsia Screening	For all pregnant females
Well-woman visits Services that may be provided during the well-woman visit include but are not limited to the following: ▪ BRCA-related cancer risk assessment ▪ Discussion of chemoprevention for breast cancer ▪ Intimate partner violence screening ▪ Primary care interventions to promote and support breast health ▪ Recommended preventive preconception and prenatal care services ▪ Urinary incontinence screening	At least annually
SCREENINGS	**COVERAGE LIMITS**
Anxiety screening	All females
Bacteriuria screening	All asymptomatic pregnant females at 12 to 16 weeks' gestation or at the first prenatal visit, if later
Counseling interventions to prevent perinatal depression	Pregnant or postpartum females at increased risk for perinatal depression without a current diagnosis of depression 20 sessions over a 70 week period
BRCA-related cancer risk assessment, genetic counseling, and BRCA mutation testing	Genetic counseling for asymptomatic females with an ancestry associated with the BCRA gene mutations, personal history or family history or a BRCA-related cancer BRCA mutation testing, as indicated, following genetic counseling

Breast cancer screening (2D or 3D mammography) • Includes any additional imaging (magnetic resonance imaging (MRI), ultrasound, mammography) and pathology evaluation needed to complete the screening process or to address findings on initial	All females aged 35 years and older, with or without clinical breast examination

screening mammography	
Cervical cancer screening (Pap test)	Ages 21 to 65: Every three years Ages 30 to 65: Every 5 years with a combination of Pap test and human papillomavirus (HPV) testing, for those who want to lengthen the screening interval
Chlamydia screening	Sexually active females ages 24 years and Younger or older sexually active females who are at increased risk for infection
Diabetes mellitus screening after pregnancy	Females with a history of gestational diabetes who are currently not pregnant and who have not been previously diagnosed with type 2 diabetes mellitus
Depression screening	All pregnant and post-partum females
Gestational diabetes mellitus screening	Asymptomatic pregnant females after 24 weeks of gestation or at the first prenatal visit for pregnant females identified to be at high risk for diabetes
Gonorrhea screening	Sexually active females ages 24 years and Younger or older sexually active females who are at increased risk for infection
Hepatitis B virus (HBV) screening	All pregnant females or asymptomatic adolescents and adults at high risk for HBV infection
Human immunodeficiency virus (HIV) screening	All pregnant females
Human papillomavirus (HPV) screening	Ages 30 and older: Every five years Ages 30 to 65: Every five years with a combination of Pap test and HPV testing, for those that want to lengthen the screening interval
Osteoporosis (bone mineral density) screening	Every two (2) years for females Younger than 65 years who are at increased risk for osteoporosis Every two (2) years for females aged 65 years and older without a history of osteoporotic fracture or without a history of osteoporosis secondary to another condition
Patient Navigation Services for Breast and Cervical Cancer Screening	All females receiving breast and/or cervical cancer screening services
RhD incompatibility screening	All pregnant females and follow-up testing for females at higher risk
Syphilis screening	All pregnant females at first prenatal visit For high-risk pregnant females, repeat testing in the third trimester and at delivery Females at increased risk for syphilis infection
Tobacco use counseling	All pregnant females who smoke tobacco products
Unhealthy alcohol use screening and behavioral counseling interventions	Screening for all pregnant females Behavioral counseling in a primary care setting with a positive screening results

MEDICATIONS	COVERAGE LIMITS
Breast cancer chemoprevention	Asymptomatic females aged 35 years and older without a prior diagnosis of breast cancer, ductal carcinoma in situ, or lobular carcinoma in situ, who are at high risk for breast cancer and at low risk for adverse effects from breast cancer chemoprevention
Folic acid	Daily folic acid supplements for all females planning for or capable of pregnancy
Low dose Aspirin	Aspirin for pregnant females who are at high risk for preeclampsia after 12 weeks of gestation
MISCELLANEOUS	**COVERAGE LIMITS**
Breastfeeding supplies/support/counseling	For all pregnant or nursing females
Reproductive education and counseling, contraception, and sterilization	All females with reproductive capacity

PREVENTIVE CARE SERVICES FOR CHILDREN

VISITS	COVERAGE LIMITS
Pre-birth exams	All expectant parents for the purpose of establishing a pediatric medical home
Preventive exams Services that may be provided during the preventive exam include but are not limited to the following: ▪ Behavioral counseling for skin cancer prevention ▪ Blood pressure screening ▪ Congenital heart defect ▪ Screening counseling and education provided by healthcare providers to prevent initiation of tobacco use ▪ Developmental surveillance ▪ Dyslipidemia risk assessment ▪ Hearing risk assessment for children 29 days or older ▪ Height, weight, and body mass index measurements ▪ Obesity screening ▪ Psychosocial/behavioral assessment	All children up to 21 years of age, with preventive exams provided at: ▪ 3-5 days after birth ▪ By 1 month ▪ 2 months ▪ 4 months ▪ 6 months ▪ 9 months ▪ 12 months ▪ 15 months ▪ 18 months ▪ 24 months ▪ 30 months ▪ 3 years-21 years: annual exams

SCREENINGS	COVERAGE LIMITS
Alcohol, tobacco, and drug use screening and behavioral counseling intervention	Annually for all children aged 11 years and older Annual behavioral counseling in a primary care setting for children with a positive screening result for drug or alcohol use/misuse
Autism and developmental screening	All children
Bilirubin screening	All newborns
Chlamydia screening	All sexually active children up to age 21 years
Depression screening	Annually for all children aged 12 years to 21 years
Dyslipidemia screening	Following a positive risk assessment or in children where laboratory testing is indicated
Gonorrhea screening	All sexually active children up to age 21 years
Hearing screening for newborns	All newborns
Hearing screening for children 29 days or older	Following a positive risk assessment or in children where hearing screening is indicated
Hepatitis B virus (HBV) screening	All asymptomatic adolescents at high risk for HBV infection
Human immunodeficiency virus (HIV) screening	All children
Iron deficiency Screening	All children
Lead poisoning screening	All children at risk of lead exposure
Newborn metabolic screening panel (For example, congenital hypothyroidism, hemoglobinopathies {sickle cell disease}, phenylketonuria {PKU})	All newborns up to 2 months of age
Syphilis screening	All sexually active children up to age 21 years
Vision screening	All children up to age 21 years
ADDITIONAL SCREENING SERVICES AND COUNSELING	
Behavioral counseling for prevention of sexually transmitted infections	Semiannually for all sexually active adolescents
Obesity screening and behavioral counseling	Screening is part of the preventive exam for children ages 6 years and older. Behavioral counseling for children ages 6 years and older with an age- and sex-specific body mass index (BMI) in the 95th percentile or greater
MEDICATIONS	**COVERAGE LIMITS**
Fluoride	Oral fluoride for children aged 6 months to 6 years whose water supply is deficient in fluoride
Prophylactic ocular topical medication for gonorrhea	All newborns within 24 hours after birth

MISCELLANEOUS	COVERAGE LIMITS
Fluoride varnish application	Every three months for all infants and children starting age of primary tooth eruption to 5 years of age
Tuberculosis testing	All children up to age 21 years

CHILD IMMUNIZATION SCHEDULE (NOTE: FOR AGE 19 TO 21 YEARS, REFER TO THE ADULT SCHEDULE LISTED ABOVE)

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger

UNITED STATES 2025

Vaccines and Other Immunizing Agents in the Child and Adolescent Immunization Schedule*

Monoclonal antibody	Abbreviation(s)	Trade name(s)
Respiratory syncytial virus monoclonal antibody (Nirsevimab)	RSV-mAb	Beyfortus
Vaccine	**Abbreviation(s)**	**Trade name(s)**
COVID-19 vaccine	1vCOV-mRNA	Comirnaty/Pfizer-BioNTech COVID-19 Vaccine Spikevax/Moderna COVID-19 Vaccine
	1vCOV-aPS	Novavax COVID-19 Vaccine
Dengue vaccine	DEN4CYD	Dengvaxia
Diphtheria, tetanus, and acellular pertussis vaccine	DTaP	Daptacel Infanrix
Haemophilus influenzae type b vaccine	Hib (PRP-T)	ActHIB Hiberix
	Hib (PRP-OMP)	PedvaxHIB
Hepatitis A vaccine	HepA	Havrix Vaqta
Hepatitis B vaccine	HepB	Engerix-B Recombivax HB
Human papillomavirus vaccine	HPV	Gardasil 9
Influenza vaccine (inactivated: egg-based)	IIV3	Multiple
Influenza vaccine (inactivated: cell-culture)	ccIIV3	Flucelvax
Influenza vaccine (live, attenuated)	LAIV3	FluMist
Measles, mumps, and rubella vaccine	MMR	M-M-R II Priorix
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-CRM	Menveo
	MenACWY-TT	MenQuadfi
Meningococcal serogroup B vaccine	MenB-4C	Bexsero
	MenB-FHbp	Trumenba
Meningococcal serogroup A, B, C, W, Y vaccine	MenACWY-TT/ MenB-FHbp	Penbraya
Mpox vaccine	Mpox	Jynneos
Pneumococcal conjugate vaccine	PCV15 PCV20	Vaxneuvance Prevnar 20
Pneumococcal polysaccharide vaccine	PPSV23	Pneumovax 23
Poliovirus vaccine (inactivated)	IPV	Ipol
Respiratory syncytial virus vaccine	RSV	Abrysvo
Rotavirus vaccine	RV1 RV5	Rotarix RotaTeq
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Adacel Boostrix
Tetanus and diphtheria vaccine	Td	Tenivac Tdvax
Varicella vaccine	VAR	Varivax
Combination vaccines *(use combination vaccines instead of separate injections when appropriate)*		
DTaP, hepatitis B, and inactivated poliovirus vaccine	DTaP-HepB-IPV	Pediarix
DTaP, inactivated poliovirus, and *Haemophilus influenzae* type b vaccine	DTaP-IPV/Hib	Pentacel
DTaP and inactivated poliovirus vaccine	DTaP-IPV	Kinrix Quadracel
DTaP, inactivated poliovirus, *Haemophilus influenzae* type b, and hepatitis B vaccine	DTaP-IPV-Hib-HepB	Vaxelis
Measles, mumps, rubella, and varicella vaccine	MMRV	ProQuad

*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

11/21/2024

How to use the child and adolescent immunization schedule

1. Determine recommended vaccine by age **(Table 1)**
2. Determine recommended interval for catch-up vaccination **(Table 2)**
3. Assess need for additional recommended vaccines by medical condition or other indication **(Table 3)**
4. Review vaccine types, frequencies, intervals, and considerations for special situations **(Notes)**
5. Review contraindications and precautions for vaccine types **(Appendix)**
6. Review new or updated ACIP guidance **(Addendum)**

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/acip/index.html) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American Academy of Pediatrics (www.aap.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Associates (www.aapa.org), and National Association of Pediatric Nurse Practitioners (www.napnap.org).

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or 800-822-7967

Questions or comments

Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays.

Download the CDC Vaccine Schedules app for providers at www.cdc.gov/vaccines/hcp/imz-schedules/app.html

Helpful information

- Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/acip-recs/hcp/vaccine-specific/index.html
- ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/acip/vaccine-recommendations/shared-clinical-decision-making.html
- *General Best Practice Guidelines for Immunization* (including contraindications and precautions): www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/index.html
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): www.cdc.gov/surv-manual/php/

U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

CHILD PREVENTIVE SCHEDULE, CONTINUED.

Table 1 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars. To determine minimum intervals between doses, see the catch-up schedule (Table 2).

Vaccine and other immunizing agents	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs
Respiratory syncytial virus (RSV-mAb [Nirsevimab])	1 dose depending on maternal RSV vaccination status (See Notes)				1 dose (8 through 19 months), See Notes												
Hepatitis B (HepB)	1st dose	←2nd dose→			←3rd dose→												
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1st dose	2nd dose	See Notes												
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1st dose	2nd dose	3rd dose			←4th dose→				5th dose					
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	See Notes		←3rd or 4th dose (See Notes)→										
Pneumococcal conjugate (PCV15, PCV20)			1st dose	2nd dose	3rd dose		←4th dose→										
Inactivated poliovirus (IPV)			1st dose	2nd dose	←3rd dose→							4th dose					See Notes
COVID-19 (1vCOV-mRNA, 1vCOV-aPS)					1 or more doses of 2024–2025 vaccine (See Notes)												
Influenza (IIV3, ccIIV3)					1 or 2 doses annually									1 dose annually			
or																	
Influenza (LAIV3)											1 or 2 doses annually			1 dose annually			
Measles, mumps, rubella (MMR)					See Notes		←1st dose→					2nd dose					
Varicella (VAR)							←1st dose→					2nd dose					
Hepatitis A (HepA)					See Notes		2-dose series (See Notes)										
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)														1 dose			
Human papillomavirus (HPV)														See Notes			
Meningococcal (MenACWY-CRM ≥2 mos, MenACWY-TT ≥2years)			See Notes											1st dose		2nd dose	
Meningococcal B (MenB-4C, MenB-FHbp)														See Notes			
Respiratory syncytial virus vaccine (RSV [Abrysvo])														Seasonal administration during pregnancy (See Notes)			
Dengue (DEN4CYD: 9–16 yrs)													Seropositive in endemic dengue areas (See Notes)				
Mpox																	

Range of recommended ages for all children

Range of recommended ages for catch-up vaccination

Range of recommended ages for certain high-risk groups or populations

Recommended vaccination can begin in this age group

Recommended vaccination based on shared clinical decision-making

No Guidance/ Not Applicable

CHILD PREVENTIVE SCHEDULE, CONTINUED.

Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 Month Behind, United States, 2025

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with Table 1 and the Notes that follow.**

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Children age 4 months through 6 years					
Hepatitis B	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose** minimum age for the final dose is 24 weeks		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	**4 weeks**	**4 weeks** maximum age for final dose is 8 months, 0 days		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months** A fifth dose is not necessary if the fourth dose was administered at age 4 years or older ***and*** at least 6 months after dose 3
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose)** if first dose was administered at age 12 through 14 months.	**No further doses needed** if previous dose was administered at age 15 months or older **4 weeks** if current age is younger than 12 months ***and*** first dose was administered at younger than age 7 months ***and*** at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix), Vaxelis or unknown **8 weeks *and* age 12 through 59 months (as final dose)** if current age is younger than 12 months ***and*** first dose was administered at age 7 through 11 months; **OR** if current age is 12 through 59 months ***and*** first dose was administered before the 1st birthday ***and*** second dose was administered at younger than 15 months; **OR** if both doses were PedvaxHIB and were administered before the 1st birthday	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older **4 weeks** if first dose was administered before the 1st birthday **8 weeks (as final dose for healthy children)** if first dose was administered at the 1st birthday or after	**No further doses needed** for healthy children if previous dose was administered at age 24 months or older **4 weeks** if current age is younger than 12 months ***and*** previous dose was administered at <7 months old **8 weeks (as final dose for healthy children)** if previous dose was administered between 7–11 months (wait until at least 12 months old); **OR** if current age is 12 months or older ***and*** at least 1 dose was administered before age 12 months	**8 weeks (as final dose)** This dose is only necessary for children age 12 through 59 months regardless of risk, or age 60 through 71 months with any risk, who received 3 doses before age 12 months.	
Inactivated poliovirus	6 weeks	**4 weeks**	**4 weeks** if current age is <4 years **6 months (as final dose)** if current age is 4 years or older	**6 months (minimum age 4 years for final dose)**	
Measles, mumps, rubella	12 months	**4 weeks**			
Varicella	12 months	**3 months**			
Hepatitis A	12 months	**6 months**			
Meningococcal ACWY	2 months MenACWY-CRM 2 years MenACWY-TT	**8 weeks**	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	**8 weeks**			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	**4 weeks**	**4 weeks** if first dose of DTaP/DT was administered before the 1st birthday **6 months (as final dose)** if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday	**6 months** if first dose of DTaP/DT was administered before the 1st birthday	
Human papillomavirus	9 years	**Routine dosing intervals are recommended.**			
Hepatitis A	N/A	**6 months**			
Hepatitis B	N/A	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose**		
Inactivated poliovirus	N/A	**4 weeks**	**6 months** A fourth dose is not necessary if the third dose was administered at age 4 years or older ***and*** at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years **OR** if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older			
Dengue	9 years	**6 months**	6 months		

CHILD PREVENTIVE SCHEDULE, CONTINUED.

Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2025

Always use this table in conjunction with Table 1 and the Notes that follow. Medical conditions are often not mutually exclusive. If multiple conditions are present, refer to guidance in all relevant columns. See Notes for medical conditions not listed.

Vaccine and other immunizing agents	Pregnancy	Immunocompromised (excluding HIV infection)	HIV infection CD4 percentage and count[a]: <15% or <200/mm³	HIV infection CD4 percentage and count[a]: ≥15% and ≥200/mm³	CSF leak or cochlear implant	Asplenia or persistent complement component deficiencies	Heart disease or chronic lung disease	Kidney failure, End-stage renal disease or on dialysis	Chronic liver disease	Diabetes
RSV-mAb (nirsevimab)		2nd RSV season		1 dose depending on maternal RSV vaccination status (See Notes)			2nd RSV season for chronic lung disease (See Notes)	1 dose depending on maternal RSV vaccination status (See Notes)		
Hepatitis B										
Rotavirus		SCID[b]								
DTaP/Tdap	DTaP Tdap: 1 dose each pregnancy									
Hib		HSCT: 3 doses	See Notes			See Notes				
Pneumococcal										
IPV										
COVID-19		See Notes								
Influenza inactivated		Solid organ transplant: 18yrs (See Notes)								
LAIV3							Asthma, wheezing: 2–4 years[c]			
MMR	*									
VAR	*									
Hepatitis A										
HPV	*	3-dose series (See Notes)								
MenACWY										
MenB										
RSV (Abrysvo)	Seasonal administration (See Notes)									
Dengue										
Mpox	See Notes									

- Recommended for all age-eligible children who lack documentation of a complete vaccination series
- Not recommended for all children, but recommended for some children based on increased risk for or severe outcomes from disease
- Recommended for all age-eligible children, and additional doses may be necessary based on medical condition or other indications. See Notes.
- Precaution: Might be indicated if benefit of protection outweighs risk of adverse reaction
- Contraindicated or not recommended *Vaccinate after pregnancy, if indicated
- No Guidance/ Not Applicable

a. For additional information regarding HIV laboratory parameters and use of live vaccines, see the General Best Practice Guidelines for Immunization, "Altered Immunocompetence," at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html and Table 4-1 (footnote J) at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

b. Severe Combined Immunodeficiency

c. LAIV3 contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months

CHILD PREVENTIVE SCHEDULE, CONTINUED.

Notes Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2025.

Additional information

- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age appropriate. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3-2, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccination requirements and recommendations is available at www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Barnett ED, Lynfield Ruth, Sawyer MH, eds. *Red Book: 2021–2024 Report of the Committee on Infectious Diseases*. 32nd ed. Itasca, IL: American Academy of Pediatrics; 2021:72–86).
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All vaccines included in the child and adolescent vaccine schedule are covered by VICP except dengue, PPSV23, RSV, Mpox and COVID-19 vaccines. Mpox and COVID-19 vaccines are covered by the Countermeasures Injury Compensation Program (CICP). For more information, see www.hrsa.gov/vaccinecompensation or www.hrsa.gov/cicp.

COVID-19 vaccination
(minimum age: 6 months [Moderna and Pfizer-BioNTech COVID-19 vaccines], 12 years [Novavax COVID-19 Vaccine])

Routine vaccination

Age 6 months–4 years

All vaccine doses should be from the same manufacturer.

- **Unvaccinated:**
  - 2 doses 2024–25 Moderna at 0, 4–8 weeks
  - 3 doses 2024–25 Pfizer-BioNTech at 0, 3–8, and at least 8 weeks after dose 2
- **Incomplete initial vaccination series before 2024–25 vaccine with:**
  - **1 dose Moderna:** complete initial series with 1 dose 2024–25 Moderna 4–8 weeks after most recent dose
  - **1 dose Pfizer-BioNTech:** complete initial series with 2 doses 2024–25 Pfizer-BioNTech 8 weeks apart (administer dose 1 3–8 weeks after most recent dose).
  - **2 doses Pfizer-BioNTech:** complete initial series with 1 dose 2024–25 Pfizer-BioNTech at least 8 weeks after the most recent dose.
- **Completed initial vaccination series before 2024–25 vaccine with:**
  - **2 or more doses Moderna:** 1 dose 2024–25 Moderna at least 8 weeks after the most recent dose.
  - **3 or more doses Pfizer-BioNTech:** 1 dose 2024–25 Pfizer-BioNTech at least 8 weeks after the most recent dose.

Age 5–11 years

- **Unvaccinated:** 1 dose 2024–25 Moderna or Pfizer-BioNTech
- **Previously vaccinated before 2024–25 vaccine with 1 or more doses Moderna or Pfizer-BioNTech:** 1 dose 2024–25 Moderna or Pfizer-BioNTech at least 8 weeks after the most recent dose.

Age 12–18 years

- **Unvaccinated:**
  - 1 dose 2024–25 Moderna or Pfizer-BioNTech
  - 2 doses 2024–25 Novavax at 0, 3–8 weeks
- **Previously vaccinated before 2024–25 vaccine with:**
  - **1 or more doses Moderna or Pfizer-BioNTech:** 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose.
  - **1 dose Novavax:** 1 dose 2024–25 Novavax 3–8 weeks after most recent dose. If more than 8 weeks after most recent dose, administer 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech.
  - **2 or more doses Novavax:** 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose.

Special situation

Persons who are moderately or severely immunocompromised.

Age 6 months–4 years

*Use vaccine from the same manufacturer for all doses (**initial vaccination series and additional doses***).*

- **Unvaccinated:**
  - 4 doses (**3-dose initial series 2024–25 Moderna** at 0, 4 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna 6 months later [minimum interval 2 months]).May administer additional doses.*
  - 4 doses (**3-dose initial series 2024–25 Pfizer-BioNTech** at 0, 3 weeks, and at least 8 weeks after dose 2, followed by 1 dose 2024–25 Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses.*
- **Incomplete initial 3-dose vaccination series before 2024–25 vaccine:**
  - **Previous vaccination with Moderna**
    - **1 dose Moderna:** complete initial series with 2 doses 2024–25 Moderna at least 4 weeks apart (administer dose 1 4 weeks after most recent dose), followed by 1 dose 2024–25 Moderna 6 months later (minimum interval 2 months). May administer additional doses of Moderna.*
    - **2 doses Moderna:** complete initial series with 1 dose 2024–25 Moderna at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna 6 months later (minimum interval 2 months). May administer additional doses of Moderna.*
  - **Previous vaccination with Pfizer-BioNTech**
    - **1 dose Pfizer-BioNTech:** complete initial series with 2 doses 2024–25 Pfizer-BioNTech at least 8 weeks apart (administer dose 1 3 weeks after most recent dose), followed by 1 dose 2024–25 Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Pfizer-BioNTech.*
    - **2 doses Pfizer-BioNTech:** complete initial series with 1 dose 2024–25 Pfizer-BioNTech at least 8 weeks after most recent dose, followed by 1 dose 2024–25 Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Pfizer-BioNTech.*

CHILD PREVENTIVE SCHEDULE, CONTINUED.

Notes Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

COVID-19 vaccination - *continued*

- **Completed initial 3-dose vaccination series before 2024–25 vaccine with:**
  - **3 or more doses Moderna:** 2 doses 2024–25 Moderna 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses of Moderna.*
  - **3 or more doses Pfizer-BioNTech:** 2 doses 2024–25 Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses of Pfizer-BioNTech.*

Age 5–11 years

Use vaccine from the same manufacturer for all doses in the initial vaccination series.

- **Unvaccinated:**
  - 4 doses (**3-dose initial series 2024–25 Moderna** at 0, 4 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses.*
  - 4 doses (**3-dose initial series 2024–25 Pfizer-BioNTech** at 0, 3 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses.*
- **Incomplete initial 3-dose vaccination series before 2024–25 vaccine:**
  - **Previous vaccination with Moderna**
    - **1 dose Moderna:** complete initial series with 2 doses 2024–25 Moderna at least 4 weeks apart (administer dose 1 4 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Pfizer-BioNTech.*
    - **2 doses Moderna:** complete initial series with 1 dose 2024–25 Moderna at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Pfizer-BioNTech.*
  - **Previous vaccination with Pfizer-BioNTech**
    - **1 dose Pfizer-BioNTech:** complete initial series with 2 doses 2024–25 Pfizer-BioNTech at least 4 weeks apart (administer dose 1 3 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Pfizer-BioNTech.*
    - **2 doses Pfizer-BioNTech:** complete initial series with 1 dose 2024–25 Pfizer-BioNTech at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Pfizer-BioNTech.*
- **Completed initial 3-dose vaccination series before 2024–25 vaccine with:**
  - **3 or more doses Moderna or 3 or more doses Pfizer-BioNTech:** 2 doses 2024–25 Moderna or Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses of Moderna or Pfizer-BioNTech.*

Age 12–18 years

Use vaccine from the same manufacturer for all doses in the initial vaccination series.

- **Unvaccinated:**
  - 4 doses (**3-dose initial series Moderna** at 0, 4 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
  - 4 doses (**3-dose initial series Pfizer-BioNTech** at 0, 3 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
  - 3 doses (**2-dose initial series Novavax** at 0, 3 weeks, followed by 1 dose Moderna or Novavax or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
- **Incomplete initial vaccination series before 2024–25 vaccine:**
  - **Previous vaccination with Moderna**
    - **1 dose Moderna:** complete initial series with 2 doses 2024–25 Moderna at least 4 weeks apart (administer dose 1 4 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
    - **2 doses Moderna:** complete initial series with 1 dose 2024–25 Moderna at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
  - **Previous vaccination with Pfizer-BioNTech**
    - **1 dose Pfizer-BioNTech:** complete initial series with 2 doses 2024–25 Pfizer-BioNTech at least 4 weeks apart (administer dose 1 3 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
    - **2 doses Pfizer-BioNTech:** complete initial series with 1 dose 2024–25 Pfizer-BioNTech at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
  - **Previous vaccination with Novavax**
    - **1 dose Novavax:** complete initial series with 1 dose 2024–25 Novavax at least 3 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*

Notes Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

COVID-19 vaccination - *continued*

- **Completed initial 3-dose vaccination series before 2024–25 vaccine with:**
  - **3 or more doses Moderna or 3 or more doses Pfizer-BioNTech:** 2 doses 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
  - **2 or more doses Novavax:** 2 doses 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*

***Additional doses of 2024–25 COVID-19 vaccine for moderately or severely immunocompromised:** based on shared clinical decision-making and administered at least 2 months after the most recent dose (see Table 2 at www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#table-02.). For description of moderate and severe immunocompromising conditions and treatment, see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#immunocompromising-conditions-treatment.

Unvaccinated persons have never received any COVID-19 vaccine doses. There is no preferential recommendation for the use of one COVID-19 vaccine over another when more than one recommended age-appropriate vaccine is available. Administer an age-appropriate COVID-19 vaccine product for each dose.

For information about transition from age 4 years to age 5 years or age 11 years to age 12 years during COVID-19 vaccination series, see Tables 1 and 2 at www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html.

For information about interchangeability of COVID-19 vaccines, see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#interchangeability.

Current COVID-19 schedule and dosage formulation available at www.cdc.gov/covidschedule. For more information on Emergency Use Authorization (EUA) indications for COVID-19 vaccines, see www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines.

Dengue vaccination (minimum age: 9 years)

Routine vaccination

- Age 9–16 years living in areas with endemic dengue **AND** have laboratory confirmation of previous dengue infection
  - 3-dose series administered at 0, 6, and 12 months
- Endemic areas include Puerto Rico, American Samoa, US Virgin Islands, Federated States of Micronesia, Republic of Marshall Islands, and the Republic of Palau. For updated guidance on dengue endemic areas and pre-vaccination laboratory testing see www.cdc.gov/mmwr/volumes/70/rr/rr7006a1.htm?s_cid=rr7006a1_w and www.cdc.gov/dengue/index.html
- Dengue vaccine should not be administered to children traveling to or visiting endemic dengue areas.

Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix or Quadracel])

Routine vaccination

- 5-dose series (3-dose primary series at age 2, 4, and 6 months, followed by booster doses at ages 15–18 months and 4–6 years)
  - **Prospectively:** Dose 4 may be administered as early as age 12 months if at least 6 months have elapsed since dose 3.
  - **Retrospectively:** A 4th dose that was inadvertently administered as early as age 12 months may be counted if at least 4 months have elapsed since dose 3.

Catch-up vaccination

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older and at least 6 months after dose 3.
- For other catch-up guidance, see Table 2.

Special situations

- **Children younger than age 7 years with a contraindication specific to the pertussis component of DTaP:** May administer Td for all recommended remaining doses in place of DTaP. Encephalopathy within 7 days of vaccination when not attributable to another identifiable cause is the only contraindication specific to the pertussis component of DTaP. For additional information, see www.cdc.gov/pertussis/hcp/vaccine-recommendations/td-offlabel.html.
- **Wound management in children younger than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine:** For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

Haemophilus influenzae type b vaccination (minimum age: 6 weeks)

Routine vaccination

- **ActHIB, Hiberix, Pentacel, or Vaxelis:** 4-dose series (3-dose primary series at age 2, 4, and 6 months, followed by a booster dose* at age 12–15 months)
  - *Vaxelis is not recommended for use as a booster dose. A different Hib-containing vaccine should be used for the booster dose.
- **PedvaxHIB:** 3-dose series (2-dose primary series at age 2 and 4 months, followed by a booster dose at age 12–15 months)
- **American Indian and Alaska Native infants:** Vaxelis and PedvaxHIB preferred over other Hib vaccines for the primary series.

Catch-up vaccination

- **Dose 1 at age 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before age 12 months and dose 2 before age 15 months:** Administer dose 3 (final dose) at least 8 weeks after dose 2.
- **2 doses of PedvaxHIB before age 12 months:** Administer dose 3 (final dose) at age12–59 months and at least 8 weeks after dose 2.
- **1 dose administered at age 15 months or older:** No further doses needed
- **Unvaccinated at age 15–59 months:** Administer 1 dose.
- **Previously unvaccinated children age 60 months or older who are not considered high risk:** Catch-up vaccination not required.

For other catch-up guidance, see Table 2. Vaxelis can be used for catch-up vaccination in children younger than age 5 years. Follow the catch-up schedule even if Vaxelis is used for one or more doses. For detailed information on use of Vaxelis see www.cdc.gov/mmwr/volumes/69/wr/mm6905a5.htm.

CHILD PREVENTIVE SCHEDULE, CONTINUED.

Notes Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Haemophilus influenzae type b vaccination
- continued

Special situations

- **Chemotherapy or radiation treatment:**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.
- **Hematopoietic stem cell transplant (HSCT):**
  - 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant, regardless of Hib vaccination history
- **Anatomic or functional asplenia (including sickle cell disease):**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated* persons age 5 years or older
  - 1 dose
- **Elective splenectomy:**
  Unvaccinated* persons age 15 months or older
  - 1 dose (preferably at least 14 days before procedure)
- **HIV infection:**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated* persons age 5–18 years
  - 1 dose
- **Immunoglobulin deficiency, early component complement deficiency, or early component complement inhibitor use:**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Unvaccinated* = Less than routine series (through age 14 months) **or no doses (age 15 months or older)

Hepatitis A vaccination
(minimum age: 12 months for routine vaccination)

Routine vaccination

- **2-dose series** (minimum interval: 6 months) at age 12–23 months

Catch-up vaccination

- **Unvaccinated persons through age 18 years should complete a 2-dose series** (minimum interval: 6 months).
- Persons who previously received 1 dose at age 12 months or older should receive dose 2 at least 6 months after dose 1.
- Adolescents age 18 years or older may receive HepA-HepB (Twinrix) as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

International travel

- Persons traveling to or working in countries with high or intermediate endemic hepatitis A (www.cdc.gov/travel/):
  - **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2 doses (separated by at least 6 months) between age 12–23 months.
  - **Unvaccinated age 12 months or older:** Administer dose 1 as soon as travel is considered.

Hepatitis B vaccination
(minimum age: birth)

Routine vaccination

- **Mother is HBsAg-negative**
  - 3-dose series at age 0, 1–2, 6–18 months (**use monovalent HepB vaccine for doses administered before age 6 weeks**)
    - Birth weight ≥2,000 grams: 1 dose within 24 hours of birth if medically stable
    - Birth weight <2,000 grams: 1 dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still <2,000 grams)
  - Infants who did not receive a birth dose should begin the series as soon as possible (see Table 2 for minimum intervals).
  - Administration of 4 doses is permitted when a combination vaccine containing HepB is used after the birth dose.
  - **Minimum intervals (see Table 2):** when 4 doses are administered, substitute "dose 4" for "dose 3" in these calculations.
  - **Final (3rd or 4th) dose:** age 6–18 months (**minimum age 24 weeks**)
- **Mother is HBsAg-positive**
  - **Birth dose (monovalent HepB vaccine only):** administer **HepB vaccine** and **hepatitis B immune globulin (HBIG)** in separate limbs within 12 hours of birth, regardless of birth weight.
  - **Birth weight <2000 grams:** administer 3 additional doses of HepB vaccine beginning at age 1 month (total of 4 doses).
  - **Final (3rd or 4th) dose:** administer at age 6 months (**minimum age 24 weeks**).
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose. Do not test before age 9 months.

WHITE SPACE INTENTIONALLY LEFT BLANK

Notes Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Hepatitis B vaccination - *continued*

- **Mother is HBsAg-unknown**
  If other evidence suggestive of maternal hepatitis B infection exists (e.g., presence of HBV DNA, HBeAg-positive, or mother known to have chronic hepatitis B infection), manage infant as if mother is HBsAg-positive.
  - **Birth dose (monovalent HepB vaccine only):**
    - Birth weight ≥2,000 grams: administer **HepB vaccine** within 12 hours of birth. Determine mother's HBsAg status as soon as possible. If mother is determined to be HBsAg-positive, administer **HBIG** as soon as possible (in separate limb), but no later than 7 days of age.
    - Birth weight <2,000 grams: administer **HepB vaccine** and **HBIG** (in separate limbs) within 12 hours of birth. Administer 3 additional doses of **HepB vaccine** beginning at age 1 month (total of 4 doses).
  - **Final (3rd or 4th) dose:** administer at age 6 months (**minimum age 24 weeks**).
  - If mother is determined to be HBsAg-positive or if status remains unknown, test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose. Do not test before age 9 months.

Catch-up vaccination

- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months. See Table 2 for minimum intervals.
- Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB** only).
- Adolescents age 18 years may receive:
  - **Heplisav-B:** 2-dose series at least 4 weeks apart
  - **PreHevbrio***: 3-dose series at 0, 1, and 6 months
  - **HepA-HepB (Twinrix):** 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

Special situations

- Revaccination is generally not recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.
- **Post-vaccination serology testing and revaccination** (if anti-HBs <10mIU/mL) is recommended for certain populations, including:
  - Infants born to HBsAg-positive mothers
  - Persons who are predialysis or on maintenance dialysis
  - Other immunocompromised persons
  - For detailed revaccination recommendations, see www.cdc.gov/mmwr/volumes/67/rr/rr6701a1.htm.

***Note:** PreHevbrio is not recommended in pregnancy due to lack of safety data in pregnant persons.

Human papillomavirus vaccination (minimum age: 9 years)

Routine and catch-up vaccination

- HPV vaccination routinely recommended at **age 11–12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated.
- 2- or 3-dose series depending on age at initial vaccination:
  - **Age 9–14 years at initial vaccination**: 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
  - **Age 15 years or older at initial vaccination**: 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2 = 4 weeks; dose 2 to dose 3 = 12 weeks; dose 1 to dose 3 = 5 months; repeat dose if administered too soon)
- No additional dose recommended when any HPV vaccine series **of any valency** has been completed using recommended dosing intervals.

Special situations

- **Immunocompromising conditions, including HIV infection:** 3-dose series, even for those who initiate vaccination at age 9 through 14 years.
- **History of sexual abuse or assault:** Start at age 9 years
- **Pregnancy:** Pregnancy testing not needed before vaccination; HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant

WHITE SPACE INTENTIONALLY LEFT BLANK

Influenza vaccination (minimum age: 6 months [IIV3], 2 years [LAIV3],18 years [recombinant influenza vaccine, RIV3])

Routine vaccination

- Use any influenza vaccine appropriate for age and health status annually:
  - **Age 6 months–8 years** who have received fewer than 2 influenza vaccine doses before July 1, 2024, or whose influenza vaccination history is unknown: 2 doses, separated by at least 4 weeks. Administer dose 2 even if the child turns 9 years between receipt of dose 1 and dose 2.
  - **Age 6 months–8 years** who have received at least 2 influenza vaccine doses before July 1, 2024: 1 dose.
  - **Age 9 years or older:** 1 dose
  - **Age 18 years solid organ transplant recipients receiving immunosuppressive medications:** high-dose inactivated (HD-IIV3) and adjuvanted inactivated (aIIV3) influenza vaccines are acceptable options. No preference over other age-appropriate IIV3 or RIV3.
- For the 2024–25 season, see www.cdc.gov/mmwr/volumes/73/rr/rr7305a1.htm.
- For the 2025–26 season, see the 2025–26 ACIP influenza vaccine recommendations.

Special situations

- **Close contacts (e.g., household contacts) of severely immunosuppressed persons who require a protected environment:** should not receive LAIV3. If LAIV3 is given, they should avoid contact with, or caring for such immunosuppressed persons for 7 days after vaccination.

Note: Persons with an egg allergy can receive any influenza vaccine (egg-based or non-egg based) appropriate for age and health status.

CHILD PREVENTIVE SCHEDULE, CONTINUED.

Notes Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Measles, mumps, and rubella vaccination
(minimum age: 12 months for routine vaccination)

Routine vaccination
- 2-dose series at age 12–15 months, age 4–6 years
- MMR or MMRV* may be administered

Note: For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV* may be used if parents or caregivers express a preference.

Catch-up vaccination
- **Unvaccinated children and adolescents:** 2-dose series at least 4 weeks apart*
- The maximum age for use of MMRV* is 12 years.

Special situations
- **International travel**
  - **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2-dose series at age 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.*
  - **Children age 12 months or older:**
    - Unvaccinated: 2-dose series (separated by at least 4 weeks*) before departure
    - Previously received 1 dose: administer dose 2 at least 4 weeks after dose 1*
- In mumps outbreak settings, for information about additional doses of MMR (including 3rd dose of MMR), see www.cdc.gov/mmwr/volumes/67/wr/mm6701a7.htm

***Note:** If MMRV is used, the minimum interval between MMRV doses is 3 months.

WHITE SPACE INTENTIONALLY LEFT BLANK

Meningococcal serogroup A,C,W,Y vaccination
(minimum age: 2 months [MenACWY-CRM, Menveo], 2 years [MenACWY-TT, MenQuadfi]), 10 years [MenACWY-TT/MenB-FHbp, Penbraya])

Routine vaccination
- 2-dose series at age 11–12 years; 16 years

Catch-up vaccination
- **Age 13–15 years:** 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)
- **Age 16–18 years:** 1 dose

Special situations
Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:
- **Menveo***
  - Dose 1 at age 2 months: 4-dose series (additional 3 doses at age 4, 6, and 12 months)
  - Dose 1 at age 3–6 months: 3- or 4-dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
  - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart
- **MenQuadfi**
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

Travel to countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj (www.cdc.gov/travel/)**:**
- **Children younger than age 24 months:**
  - **Menveo* (age 2–23 months)**
    - Dose 1 at age 2 months: 4-dose series (additional 3 doses at age 4, 6, and 12 months)
    - Dose 1 at age 3–6 months: 3- or 4-dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
    - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
- **Children age 2 years or older:** 1 dose Menveo* or MenQuadfi

First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits: 1 dose Menveo* or MenQuadfi

Adolescent vaccination of children who received MenACWY prior to age 10 years:
- **Children for whom boosters are recommended because of an ongoing increased risk of meningococcal disease** (e.g., those with complement component deficiency, HIV, or asplenia): Follow the booster schedule for persons at increased risk.
- **Children for whom boosters are not recommended** (e.g., a healthy child who received a single dose for travel to a country where meningococcal disease is endemic): Administer MenACWY according to the recommended adolescent schedule with dose 1 at age 11–12 years and dose 2 at age 16 years.

**Menveo has two formulations: lyophilized and liquid. The liquid formulation should not be used before age 10 years. See www.cdc.gov/vaccines/vpd/mening/downloads/menveo-single-vial-presentation.pdf.*

Note: For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Children age 10 years or older may receive a single dose of Penbraya as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day (see "Meningococcal serogroup B vaccination" section below for more information).

WHITE SPACE INTENTIONALLY LEFT BLANK

CHILD PREVENTIVE SCHEDULE, CONTINUED.

Notes Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Meningococcal serogroup B vaccination
(minimum age: 10 years [MenB-4C, Bexsero; MenB-FHbp, Trumenba; MenACWY-TT/MenB-FHbp, Penbraya])

Shared clinical decision-making
- **Adolescents not at increased risk age 16–23 years (preferred age 16–18 years)* based on shared clinical decision-making.**
  - **Bexsero or Trumenba (use same brand for all doses):** 2-dose series at least 6 months apart (if dose 2 is administered earlier than 6 months, administer dose 3 at least 4 months after dose 2)

*To optimize rapid protection (e.g., for students starting college in less than 6 months), a 3-dose series (0, 1–2, 6 months) may be administered.

For additional information on shared clinical decision-making for MenB, see www.cdc.gov/vaccines/hcp/admin/downloads/isd-job-aid-scdm-mening-b-shared-clinical-decision-making.pdf

Special situations
Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use.
- **Bexsero or Trumenba (use same brand for all doses including booster doses)** 3-dose series at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed; if dose 3 is administered earlier than 4 months after dose 2, a 4th dose should be administered at least 4 months after dose 3)

For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Note: MenB vaccines may be administered simultaneously with MenACWY vaccines if indicated, but at a different anatomic site, if feasible.

Children age 10 years or older may receive a dose of Penbraya (MenACWY–TT/MenB–FHbp) as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day. For age-eligible children not at increased risk, if Penbraya is used for dose 1 MenB, MenB-FHbp (Trumenba) should be administered for dose 2 MenB. For age-eligible children at increased risk of meningococcal disease, Penbraya may be used for additional MenACWY and MenB doses (including booster doses) if both would be given on the same clinic day **and** at least 6 months have elapsed since most recent Penbraya dose.

Mpox vaccination
(minimum age: 18 years [Jynneos])

Special situations
- **Age 18 years and at risk for mpox infection:** complete 2-dose series, 28 days apart.

  Risk factors for mpox infection include:
  - Persons who are gay, bisexual, and other MSM, transgender or nonbinary people who in the past 6 months have had:
    - A new diagnosis of at least 1 sexually transmitted disease
    - More than 1 sex partner
    - Sex at a commercial sex venue
    - Sex in association with a large public event in a geographic area where mpox transmission is occurring
  - Persons who are sexual partners of the persons described above
  - Persons who anticipate experiencing any of the situations described above
- **Pregnancy:** There is currently no ACIP recommendation for Jynneos use in pregnancy due to lack of safety data in pregnant persons. Pregnant persons with any risk factor described above may receive Jynneos.

For detailed information, see www.cdc.gov/mpox/hcp/vaccine-considerations/vaccination-overview.html

WHITE SPACE INTENTIONALLY LEFT BLANK

Pneumococcal vaccination
(minimum age: 6 weeks [PCV15], [PCV 20]; 2 years [PPSV23])

Routine vaccination with PCV
- 4-dose series at 2, 4, 6, 12–15 months

Catch-up vaccination with PCV
- Healthy children ages 2–4 years with any incomplete* PCV series: 1 dose PCV
- For other catch-up guidance, see Table 2.

Note: For children **without** risk conditions, PCV20 is not indicated if they have received 4 doses of PCV13 or PCV15 or another age appropriate complete PCV series.

Special situations
Children and adolescents with cerebrospinal fluid leak; chronic heart disease; chronic kidney disease (excluding maintenance dialysis and nephrotic syndrome); chronic liver disease; chronic lung disease (including moderate persistent or severe persistent asthma); cochlear implant; or diabetes mellitus:

Age 2–5 years
- Any incomplete* PCV series with:
  - 3 PCV doses: 1 dose PCV (at least 8 weeks after the most recent PCV dose)
  - Less than 3 PCV doses: 2 doses PCV (at least 8 weeks after the most recent dose and administered at least 8 weeks apart)
- Completed recommended PCV series but have not received PPSV23.
  - Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
  - Not previously received PCV20: administer 1 dose PCV20 or 1 dose PPSV23 administer at least 8 weeks after the most recent PCV dose.

Notes Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Pneumococcal vaccination - *continued*

Age 6–18 years

- Not previously received any dose of PCV13, PCV15, or PCV20: administer 1 dose of PCV15 or PCV20. If PCV15 is used and no previous receipt of PPSV23, administer 1 dose of PPSV23 at least 8 weeks after the PCV15 dose.**
- Received PCV before age 6 years but have not received PPSV23
  - Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
  - Not previously received PCV20: 1 dose PCV20 or 1 dose PPSV23 administer at least 8 weeks after the most recent PCV dose.
- Received PCV13 only at or after age 6 years: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose.
- Received 1 dose PCV13 and 1 dose PPSV23 at or after age 6 years: no further doses of any PCV or PPSV23 indicated.

Children and adolescents on maintenance dialysis, or with immunocompromising conditions such as nephrotic syndrome; congenital or acquired asplenia or splenic dysfunction; congenital or acquired immunodeficiencies; diseases and conditions treated with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and solid organ transplant; HIV infection; or sickle cell disease or other hemoglobinopathies:

Age 2–5 years

- Any incomplete* PCV series:
  - 3 PCV doses: 1 dose PCV (at least 8 weeks after the most recent PCV dose)
  - Less than 3 PCV doses: 2 doses PCV (at least 8 weeks after the most recent dose and administered at least 8 weeks apart)
- Completed recommended PCV series but have not received PPSV23
  - Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
  - Not previously received PCV20: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV dose. If PPSV23 is used, administer 1 dose of PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.

Age 6–18 years

- Not previously received any dose of PCV13, PCV15, or PCV20: administer 1 dose of PCV15 or 1 dose of PCV20. If PCV15 is used and no previous receipt of PPSV23, administer 1 dose of PPSV23 at least 8 weeks after the PCV15 dose.**
- Received PCV before age 6 years but have not received PPSV23
  - Previously received at least 1 dose of PCV20: no additional dose of PCV or PPSV23
  - Not previously received PCV20: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV dose. If PPSV23 is used, administer either PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.
- Received PCV13 only at or after age 6 years: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose. If PPSV23 is used, administer 1 dose of PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.
- Received 1 dose PCV13 and 1 dose PPSV23 at or after age 6 years: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose and at least 5 years after dose 1 PPSV23.

Pregnancy: no recommendation for PCV or PPSV23 due to limited data. Summary of existing data on pneumococcal vaccination during pregnancy can be found at www.cdc.gov/mmwr/volumes/72/rr/rr7203a1.htm

For guidance on determining which pneumococcal vaccines a patient needs and when, please refer to the mobile app, which can be downloaded here: wcms-wp.cdc.gov/pneumococcal/hcp/vaccine-recommendations/app.html

**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series. See Table 2 in ACIP pneumococcal recommendations at stacks.cdc.gov/view/cdc/133252

***When both PCV15 and PPSV23 are indicated, administer all doses of PCV15 first. PCV15 and PPSV23 should not be administered during the same visit.*

Poliovirus vaccination (minimum age: 6 weeks)

Routine vaccination

- 4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose on or after age 4 years and at least 6 months after the previous dose.
- 4 or more doses of IPV can be administered before age 4 years when a combination vaccine containing IPV is used. However, a dose is still recommended on or after age 4 years and at least 6 months after the previous dose.

Catch-up vaccination

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- **Adolescents age 18 years known or suspected to be unvaccinated or incompletely vaccinated:** administer remaining doses (1, 2, or 3 IPV doses) to complete a 3-dose primary series.* Unless there are specific reasons to believe they were not vaccinated, most persons aged 18 years or older born and raised in the United States can assume they were vaccinated against polio as children.

Series containing oral poliovirus vaccine (OPV), either mixed OPV-IPV or OPV-only series:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_%20cid=mm6601a6_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.
  - Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).
  - Doses of OPV administered on or after April 1, 2016, should not be counted.
  - For guidance to assess doses documented as "OPV," see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, see Table 2.

Special situations

- **Adolescents aged 18 years at increased risk of exposure to poliovirus and completed primary series*:** may administer one lifetime IPV booster

***Note:** Complete primary series consist of at least 3 doses of IPV or trivalent oral poliovirus vaccine (tOPV) in any combination.

For detailed information, see: www.cdc.gov/vaccines/vpd/polio/hcp/recommendations.html

Notes Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Respiratory syncytial virus immunization (minimum age: birth [Nirsevimab, RSV-mAb, Beyfortus])

Routine immunization

- **Infants born October – March in most of the continental United States***
  - Mother did not receive RSV vaccine or mother's RSV vaccination status is unknown or mother received RSV vaccine in previous pregnancy: administer 1 dose nirsevimab within 1 week of birth—ideally during the birth hospitalization.
  - Mother received RSV vaccine **less than 14 days** prior to delivery: administer 1 dose nirsevimab within 1 week of birth—ideally during the birth hospitalization.
  - Mother received RSV vaccine **at least 14 days** prior to delivery: nirsevimab not needed but can be considered in rare circumstances at the discretion of healthcare providers (see www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html)
- **Infants born April–September in most of the continental United States***
  - Mother did not receive RSV vaccine or mother's RSV vaccination status is unknown or mother received RSV vaccine in previous pregnancy: administer 1 dose nirsevimab shortly before start of RSV season.*
  - Mother received RSV vaccine **less than 14 days** prior to delivery: administer 1 dose nirsevimab shortly before start of RSV season.*
  - Mother received RSV vaccine **at least 14 days** prior to delivery: nirsevimab not needed but can be considered in rare circumstances at the discretion of healthcare providers (see www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html)

Infants with prolonged birth hospitalization** (e.g., for prematurity) discharged October through March should be immunized shortly before or promptly after discharge.

Special situations

- **Ages 8–19 months with chronic lung disease of prematurity requiring medical support (e.g., chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) any time during the 6-month period before the start of the second RSV season; severe immunocompromise; cystic fibrosis with either weight for length <10th percentile or manifestation of severe lung disease (e.g., previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable)**:**
  - 1 dose nirsevimab shortly before start of second RSV season*
- **Ages 8–19 months who are American Indian or Alaska Native:** 1 dose nirsevimab shortly before start of second RSV season*
- **Age-eligible and undergoing cardiac surgery with cardiopulmonary bypass**:** 1 additional dose of nirsevimab after surgery. See www.accessdata.fda.gov/drugsatfda_docs/label/2023/761328s000lbl.pdf

***Note:** While the timing of the onset and duration of RSV season may vary, administration of nirsevimab is recommended October through March in most of the continental United States (optimally October through November or within 1 week of birth). Providers in jurisdictions with RSV seasonality that differs from most of the continental United States (e.g., Alaska, jurisdiction with tropical climate) should follow guidance from public health authorities (e.g., CDC, health departments) or regional medical centers on timing of administration based on local RSV seasonality.

****Note:** Nirsevimab can be administered to children who are eligible to receive palivizumab. Children who have received nirsevimab should not receive palivizumab for the same RSV season.

For further guidance, see www.cdc.gov/mmwr/volumes/72/wr/mm7234a4.htm and www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html

Respiratory syncytial virus vaccination (RSV [Abrysvo])

Routine vaccination

- **Pregnant at 32 weeks 0 days through 36 weeks and 6 days gestation from September through January in most of the continental United States*:** 1 dose Abrysvo. Administer RSV vaccine regardless of previous RSV infection.
  - Either maternal RSV vaccination with Abrysvo or infant immunization with nirsevimab (RSV monoclonal antibody) is recommended to prevent severe respiratory syncytial virus disease in infants.
- **All other pregnant persons:** RSV vaccine not recommended
- **Subsequent pregnancies:** additional doses not recommended. No data are available to inform whether additional doses are needed in subsequent pregnancies. Infants born to pregnant persons who received RSV vaccine during a previous pregnancy should receive nirsevimab.

***Note:** Providers in jurisdictions with RSV seasonality that differs from most of the continental United States (e.g., Alaska, jurisdictions with tropical climate) should follow guidance from public health authorities (e.g., CDC, health departments) or regional medical centers on timing of administration based on local RSV seasonality.

Rotavirus vaccination (minimum age: 6 weeks)

Routine vaccination

- **Rotarix:** 2-dose series at age 2 and 4 months
- **RotaTeq:** 3-dose series at age 2, 4, and 6 months
- If any dose in the series is either **RotaTeq** or unknown, default to 3-dose series.

Catch-up vaccination

- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Table 2.

Notes Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Tetanus, diphtheria, and pertussis (Tdap) vaccination (minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

Routine vaccination

- **Age 11–12 years:** 1 dose Tdap (adolescent booster)
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36

Note: Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination

- **Age 13–18 years who have not received Tdap:** 1 dose Tdap (adolescent booster)
- **Age 7–18 years not fully vaccinated* with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.
- **Tdap administered at age 7–10 years:**
  - **Age 7–9 years** who receive Tdap should receive the adolescent Tdap booster dose at age 11–12 years
  - **Age 10 years** who receive Tdap do not need the adolescent Tdap booster dose at age 11–12 years
- **DTaP inadvertently administered on or after age 7 years:**
  - **Age 7–9 years:** DTaP may count as part of catch-up series. Administer adolescent Tdap booster dose at age 11–12 years.
  - **Age 10–18 years:** Count dose of DTaP as the adolescent Tdap booster dose.
- For other catch-up guidance, see Table 2.

Special situations

- **Wound management** in persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap.
- For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm.

**Fully vaccinated* = 5 valid doses of DTaP or 4 valid doses of DTaP if dose 4 was administered at age 4 years or older

Varicella vaccination (minimum age: 12 months)

Routine vaccination

- 2-dose series at age 12–15 months, 4–6 years
- VAR or MMRV may be administered*
- Dose 2 may be administered as early as 3 months after dose 1 (a dose inadvertently administered after at least 4 weeks may be counted as valid).

**Note:* For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV may be used if parents or caregivers express a preference.

Catch-up vaccination

- Ensure persons age 7–18 years without evidence of immunity (see *MMWR* at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have a 2-dose series:
  - **Age 7–12 years:** Routine interval: 3 months (a dose inadvertently administered after at least 4 weeks may be counted as valid)
  - **Age 13 years and older:** Routine interval: 4–8 weeks (minimum interval: 4 weeks)
  - The maximum age for use of *MMRV* is 12 years.

WHITE SPACE INTENTIONALLY LEFT BLANK

Definitions

The following definitions contain the meanings of key terms used in this Policy. Throughout this Policy, the terms defined appear with the first letter of each word in capital letters.

90-Day Retail Pharmacy is a participating retail pharmacy that provides all the Covered Services of any other participating retail pharmacy, and also, through an agreement with Us, or with an organization contracting on Our behalf, dispenses up to a 90-day supply of prescription drugs or related supplies. Please note: not every participating pharmacy is a 90-day retail pharmacy; however, every participating pharmacy can provide a 30-day supply of prescription drugs or related supplies.

Acceptable Third-Party Payor means one or more of the following:

- The Ryan White HIV/AIDS Program established under Title XXVI of the Public Health Service Act;
- An Indian tribe, tribal organization, or urban Indian organization;
- A local, state or federal government program, including a grantee directed by a government program to make payments on its behalf; or
- An independent private entity that (i) is organized as a not-for-profit organization under state law, (ii) has received a determination from the Internal Revenue Service that the entity qualifies for an exemption from federal income tax under 26 U.S.C. § 501(c)(3), and (iii) makes payments on Your behalf solely on the basis of publicly available criteria and does not in any way consider the health status of any Insured Person in determining whether to make such payments on Your behalf.

Accidental Injury is injury to the body that is solely caused by an accident, and not by any other causes.

Allowed Amount refers to the basis on which a Member's Coinsurance, Out-of-Pocket Maximum and benefits are calculated. For services provided by a Participating Provider, the term "allowed amount" is the amount that the health plan had negotiated with the provider as total reimbursement for Covered Services.

Annual, Calendar Year, Year is a 12-month period beginning each January 1 at 12:01 a.m. Eastern Time.

Annual Open Enrollment Period means the designated period of time during each calendar year, when individuals can apply for coverage for the following year. The Annual Open Enrollment Period is set by the federal government and state, and the beginning and ending dates are subject to change each year.

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. This must be directed by a licensed professional who is personally involved in the evaluation of the member, development of the treatment plan, and monitoring of the therapy.

Autism Spectrum Disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorders not otherwise specified.

Brace is an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

Brand Name Drug (Brand Name) means a Prescription Drug that We identify as a Brand Drug across its book-of-business, principally based on available data resources, including, but not limited to, First Databank or another nationally recognized drug indicator source, that classify drugs or biologics as either Brand or Generic based on a number of factors. Not all products identified as a "Brand Name" by the manufacturer, Pharmacy, or Your Physician may be classified as a Brand Drug under the Policy.

Charges means the actual billed charges, except when the provider has contracted with Us for a different amount, including where We have contracted with an entity to arrange for the provision of Covered Services through contracts with providers of such services and/or supplies.

Coinsurance means the percentage of Covered Expenses the Insured Person is responsible for paying after applicable Deductibles are satisfied. **Coinsurance does not include Copayments. Coinsurance also does not include Charges for services that are not Covered Services or Charges in excess of Covered Expenses, or Charges which are not Covered Expenses under this Policy.**

Consumable Medical Supply means non-durable medical supplies that cannot withstand repeated use, are usually disposable, and are generally not useful to a person in the absence of illness or injury.

Copayment means a set dollar amount of Covered Expenses the Insured Person is responsible for paying. Copayment does not include Charges for services that are not Covered Services or Charges in excess of Covered Expenses. Copayments are calculated separately from Coinsurance.

Cosmetic Surgery is performed to change the appearance of characteristics or features of the patient's body where no functional deficit is present.

Cost Share is the Deductible, Copayment and Coinsurance amounts You are responsible for paying the Policy.

Covered Expenses are the expenses incurred for Covered Services under this Policy which We will consider for payment under this Policy. Covered Expenses are:

- The Negotiated Rate for Covered Services from Participating Providers.
- The reasonable amount based on industry standards for Covered Services from Non-Participating Providers.
- The Allowed Expense.

As determined by Us, Covered Expenses may include all charges made by an entity that has contracted with Us to arrange, through contracts with providers, for the provision of any Covered Services.

Covered Expenses may be limited by other specific maximums described in this Policy. Covered Expenses are subject to applicable Deductibles and other benefit limits. **An expense is incurred on the date the Insured Person <u>receives</u> the service or supply.** Covered Expenses may be less than the amount that is actually billed.

Covered Services are Medically Necessary services or supplies that:

- Are listed in the benefit sections of this Policy, and
- Are not specifically excluded by the Policy, and
- Are provided by a provider that is:
    - Licensed in accordance with any applicable federal and state laws; AND
    - Acting within the scope of the provider’s license and (if applicable) accreditation; OR
    - A Hospital, accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another appropriately licensed organization.

Custodial Care is any service that is of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in performing activities of daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person.
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) eating, (g) preparing foods, or (h) taking medications that can be self-administered; and
- Services not required to be performed by trained or skilled medical or paramedical personnel.
- The fact that a custodial parent, family member or other caregiver is not available or willing to provide such a service does not make a service which otherwise be considered a Custodial Service eligible for coverage.

Dedicated Virtual Care Medical Physician Service means a Virtual Care Service provided by a Dedicated Virtual Care Physician for minor acute medical conditions such as a cold, flu, sore throat, rash or headache.

Dedicated Virtual Care Physician means a Physician who is part of a designated network from one or more organizations contracted with Us to provide certain Virtual Care Services.

Dedicated Virtual Primary Care Physician Service means a Virtual Care Service provided by a Dedicated Virtual Care Physician for an Annual wellness check such as advice on diet, exercise and vaccinations or routine primary care needs for conditions such as diabetes, hypertension, cholesterol, asthma, or other non-urgent issues.

Deductible means the amount of Covered Expenses that must be paid for Covered Services each Year before benefits are available under this Policy. Deductibles may not apply to all services, including Preventive Services. The Deductible applies to all Covered Expenses, except for those covered under the Prescription Drugs section of this Policy a separate Prescription Drug Deductible applies only to those benefits.

Dental Prostheses are dentures, crowns, caps, bridges, clasps, habit appliances, and partials.

Diabetic Equipment includes blood glucose monitors and test strips, monitors designed to be used by blind persons; insulin pumps and associated appurtenances, insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices in the injection of insulin and any other required disposable supplies; and podiatric appliances for the prevention of complications associated with diabetes. Diabetic Equipment also includes the repair or maintenance of insulin pumps not covered under a manufacturer's warranty and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

Diabetic Pharmaceuticals and Supplies include visual reading and urine test strips; ketones and protein test strips; blood glucose monitors, therapeutic continuous glucose monitors and the associated supply items on Our Formulary; lancets and lancing devices; insulin and insulin analogs, injection aids; including devices used to assist with insulin injection and needle-less systems; syringes and hypodermic needles, prescriptive oral agents for controlling blood sugar levels; and glucagon emergency kits.

Diabetic Self-Management Training is instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as means of avoiding frequent hospitalization and complications.

Durable Medical Equipment is defined as items which:
Are designed for and able to withstand repeated use by more than one person;

- Customarily serve a therapeutic purpose with respect to a particular Illness or Injury, as certified in writing by the attending medical provider;
- Generally, are not useful in the absence of Illness or Injury;
- Are appropriate for use in the home and not intended to be used outdoors or outside the home;
- Are of a truly durable nature; and
- Are not disposable.

Such equipment includes, but is not limited to, crutches, Hospital beds, wheel chairs, respirators, and dialysis machines. This equipment does not include mobility scooters.

Effective Date is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

Emergency Medical Condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

- A medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to Stabilize the patient.
- Emergency Services if delivered in an Out-of-Network facility or by an Out-of-Network provider end when the treating provider determines that the individual is stable for transfer to an In-Network facility or by an In-Network provider.

Enrollment Area is any place that is within the state of Pennsylvania that has been designated by Us as the area where this Policy is available for enrollment.

Essential Health Benefits means to the extent covered under this Policy, expenses incurred with respect to Covered Services, in at least the following categories: ambulatory patient services, Emergency Services, hospitalization, maternity and newborn care, Mental Health and Substance Use Disorder services, including behavioral health treatment, Prescription Drugs, rehabilitative and Habilitative Services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Experimental/Investigational/Unproven Procedures means a drug, device or medical treatment or procedure is considered Experimental or Investigational or Unproven if:

- It has not been demonstrated through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or evaluating the condition or Illness for which it is proposed; or

- It has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- Reliable evidence shows it is the subject of ongoing phase I, II, III or IV clinical trial or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the current standard of treatment or diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment of diagnosis.

Reliable evidence means only: the published reports and articles in authoritative, peer-reviewed medical and scientific literature; written protocol or protocols by the treating facility or other facilities studying substantially the same drug, device or medical treatment or procedure; or the medical informed consent used by the treating facility or other facilities studying substantially the same drug, device or medical treatment or procedure.

Family Deductible applies if You and one or more of Your Family Member(s) are enrolled for coverage under this Policy. It is an accumulation of the Individual Deductibles paid by each Family Member during a Year. Each Insured Person can contribute up to the Individual Deductible amount toward the Family Deductible. Once the Family Deductible amount is satisfied in a Year, any remaining Individual Deductibles will be waived for the remainder of the Year. The Family Deductible applies to all Covered Expenses, except for those covered under the Prescription Drug section of this Policy; a separate Prescription Drug Deductible applies only to those benefits. The amount of the Family Deductible is described in the benefit schedule section of this Policy.

Family Member means Your spouse, children or other persons meeting definition of an eligible family member, and enrolled for coverage under this Policy. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled “Who is Eligible for Coverage?”

Family Out-of-Pocket Maximum applies if You and one or more of Your Family Member(s) are enrolled for coverage under this Policy. It is an accumulation of the Deductible, Coinsurance and Copayments each Family Member has accrued during a Year. Each Insured Person can contribute up to his or her Individual Out-of-Pocket amount toward the Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum has been met in a Year, You and Your Family Member(s) will no longer be responsible for paying Coinsurance or Copayments for medical or Pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. The amount of the Family Out-of-Pocket Maximum is described in the benefit schedule section of this Policy.

Family Prescription Drug Deductible applies if You and one or more of Your Family Member(s) are enrolled for coverage under this Policy. It is an accumulation of the Individual Prescription Drug Deductible paid by each Family Member during a Year. Each Insured Person can contribute up to the Individual Prescription Drug Deductible amount toward the Family Prescription Drug Deductible. Once the Family Prescription Drug Deductible amount is satisfied in a Year, any remaining Individual Prescription Drug Deductibles will be waived for the remainder of the Year. The amount of the Family Prescription Drug Deductible is described in the Prescription Drug section of the benefit schedule.

Foreign country provider is any institutional or professional provider of medical or psychiatric treatment or care who practices in a country outside the United States of America.

Free-Standing Outpatient Surgical Facility means an Institution which meets all the following requirements:
- It has a medical staff of Physicians, nurses and licensed anesthesiologists;
- It maintains at least two operating rooms and one recovery room;
- It maintains diagnostic laboratory and x-ray facilities;
- It has equipment for emergency care;

- It has a blood supply;
- It maintains medical records;
- It has agreements with Hospitals for immediate acceptance of patients who need Hospital confinement on an inpatient basis; and
- It is licensed in accordance with the laws of the appropriate legally authorized agency.

Gene Therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:
- Replacing a disease-causing gene with a healthy copy of the gene.
- Inactivating a disease-causing gene that may not be functioning properly.
- Introducing a new or modified gene into the body to help treat a disease.

Each Gene Therapy product is specific to a particular disease and is administered in a specialized manner. We determine which products are in the category of Gene Therapy, based in part on the nature of the treatment and how it is distributed and administered.

Generic Drug (Generic) means a Prescription Drug that We identify as a Generic Drug at a book-of- business level principally based on available data resources, including, but not limited to, First Databank or another nationally recognized drug indicator source, that classify drugs or biologics (including biosimilars) as either brand or generic based on a number of factors. Not all products identified as a "Generic" by the manufacturer, Pharmacy or Your Physician may be classified as a Generic Drug under the Policy.

Habilitative Services are those services that are:
- Designed to assist an individual to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame,
- Expected to result in significant and measurable therapeutic or developmental improvement over a clearly defined period of time, and
- Individualized and there is documentation outlining quantifiable, measurable and attainable treatment goals.

Health Professionals are physicians, dentists, nurses, podiatrists, optometrists, physicians' assistants, psychologists, psychiatrists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists and other professionals engaged in the delivery of health care services who are licensed under the laws of the Commonwealth.

Home Health Agencies and Visiting Nurse Associations are home health care providers that are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in Your home. They must be approved as home health care providers under the Joint Commission on Accreditation of Health Care Organizations.

Hospice Care Program means a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families; a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the Illness; a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services means palliative and supportive medical, nursing and other health services through home or inpatient care that are Covered Expenses provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar Institution, (c) a Home Health Agency and Visiting Nurse Association, (d) a hospice facility, or (e) any other licensed facility or agency under a Hospice Care Program.

Hospital means:

- An Institution licensed as a Hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses; or
- An Institution which qualifies as a Hospital, a psychiatric Hospital and a provider of services, if such Institution is accredited as a Hospital for the appropriate treatment and/or diagnosis by the Joint Commission on the Accreditation of Healthcare Organizations; or
- An Institution which: (a) specializes in the treatment of Mental Health and Substance Use Disorder or other related Illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include any Institution or facility in which a significant portion of the activities include rest, recreation, leisure, or any other services that do not consist exclusively of Covered Services.

Illness is a sickness, disease, or condition recognized by the community of physicians as abnormal and warranting medical treatment or evaluation of an Insured Person.

Indian Health Program is only applicable to an Insured Person who is a Native American or Alaska Native, and is defined as follows:

- Any health program administered directly by the Indian Health Service;
- Any Tribal Health Program; and
- Any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 47 of US Title 25, Chapter 2.

Individual Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services each Year before benefits are available under this Policy. The amount of the Individual Deductible is described in the benefit schedule section of this Policy. The Individual Deductible applies to all Covered Expenses, except for those covered under the Prescription Drugs section of this Policy; a separate Prescription Drug Deductible applies only to those benefits.

Individual Out-of-Pocket Maximum is an accumulation of Covered Expenses. It includes Deductibles, Copayments and Coinsurance for medical and Prescription Drug Covered Services. Once the Out-of-Pocket Maximum has been met for the Year, for Covered Expenses, You will no longer have to pay any Coinsurance or Copayment for medical or Pharmacy services for Covered Expenses incurred during the remainder of that Year. Non-compliance penalty charges do not apply to the Individual Out-of-Pocket Maximum and will always be paid by You. The amount of the Individual Out-of-Pocket Maximum is described in the benefit schedule section of this Policy.

Individual Prescription Drug Deductible means the amount of Covered Expenses each Insured Person must pay for Prescription Drugs and Related Supplies each Year before benefits are available for Prescription Drugs and Related Supplies under this Policy. The amount of the Individual Prescription Drug Deductible is described in the benefit schedule section of this Policy, in the Prescription Drug Benefits.

Infertility is the condition of an otherwise presumably healthy individual who is unable to conceive or produce conception during a period of one Year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

Injectable Medications are medications ordered or prescribed by a Physician and required by the Federal Drug Administration to be administered under the direct supervision of a healthcare professional. Such medications may require Prior Authorization or Step Therapy. Refer to the “Prescription Drug Benefits” section of this Policy for Prior Authorization and Step Therapy information.

Injury means an accidental bodily injury.

Institution means an establishment that furnishes food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

Insured Person means both You, the Policyholder, and all other Family Member(s) who are covered under this Policy.

Jefferson Health Plans, We, Our, and Us mean Jefferson Health Plans or an affiliate. Jefferson Health Plans is the organizational name for branding and certain products of the licensed and regulated health maintenance company.

Limited Distribution Drugs (LDDs) are drugs with special requirements used to treat conditions affecting only a small percentage of the population. Because of this, the manufacturer may choose to limit the distribution of the drug to only a few pharmacies, or as recommended by the Food and Drug Administration (FDA) for the drug as a condition of its approval of the drug. This type of restricted distribution helps the manufacturer to monitor the inventory of the drug, educate the dispensing pharmacists about the required necessary monitoring, and ensure that any associated risks are minimized.

Marketplace means a state-based Marketplace, a state partnership Marketplace, or a federally-facilitated Marketplace, as the case may be.

Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medical Foods are liquid nutritional products which are specifically formulated to treat one of the following genetic diseases: phenylketonuria, branched-chair ketonuria, galactosemia, or homocystinuria.

Medically Necessary or Dentally Necessary services or supplies are those that are determined by Us to be **all** the following:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical or dental condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Provided for the diagnosis or direct care and treatment of the medical or dental condition.
- Not primarily for the convenience of any Insured Person, Physician, or another provider.
- Within generally accepted standards of good medical practice within the community of qualified professionals.
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.
- The most appropriate procedure, supply, equipment or service which can be safely provided and that satisfies the following requirements:
  - Must have been proven by scientific studies published in peer-reviewed medical literature to be associated with beneficial health outcomes, demonstrating that the expected health benefits are clinically significant and produce a greater likelihood of benefits, without a disproportionately greater risk of harm or complications, for the patient with the medical condition being treated than other possible alternatives; and
  - Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
  - For Hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

The fact that a provider prescribed, ordered, recommended or approved a service, supply, treatment or Confinement does not in and of itself make it Medically Necessary or Dentally Necessary or a Medical or Dental Necessity.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Mental Health Disorder is defined as a condition that impairs behavior, emotional reaction or thought processes; these include, but are not limited to: depression, psychosis, mania or other psychological symptoms.

Mental Health or Substance Use Disorder Residential Treatment Center means an institution which:
- Specializes in the treatment of psychological and social disturbances that are the result of Mental Health and/or Substance Use Disorder conditions;
- Provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians, Other Health Care Professionals under the direct supervision of a Physician, or a healthcare professional independently licensed by a state to provide such services and working within the scope of his/her license (physician assistant, nurse practitioner);
- Provides 24-hour care, in which a person lives in an open setting; and
- Is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

Negotiated Rate is the rate of payment that has been negotiated by Us with a provider for Covered Services.

Newborn is an infant within 31 days of birth.

Non-Participating Pharmacy/Out-of-Network Pharmacy is a retail or home delivery Pharmacy which We have NOT contracted with to provide Prescription Drug services to Insured Persons.

Non-Participating Provider/Out-of-Network Provider is a provider who does not have a Participating Provider agreement in effect with Us for this Policy at the time services are rendered.

Nutritional Formula are liquid nutritional products which are formulated to supplement or replace normal food products. Any nutritional product:
- For which the FDA does not require a valid prescription from a licensed health care provider; or
- Is not designated to be a drug by the FDA is considered a Nutritional Formula.

Office Visit means a visit by the Insured Person, who is the patient, to the office of a Physician during which one or more of only the following specific services are provided:
- History (gathering of information on an Illness or Injury).
- Examination.
- Medical decision making (the Physician's diagnosis and plan of treatment).

This does not include other services (e.g. x-rays or lab services) even if performed on the same day.

Orthoses and Orthotic Devices are orthopedic appliances or apparatuses used to support, align, prevent or correct deformities.

Other Health Care Facility means a facility other than a Hospital or hospice facility which is operated by or has an agreement with Us to render services to Insured Persons. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing Facilities, rehabilitation Hospitals and sub- acute facilities. Other Health Care Facilities do NOT include long-term care facilities, residential facilities, care homes, rest homes, or assisted living facilities.

Other Health Care Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and who has an agreement with Us to render services to Insured Persons. Other Health Care Professionals include, but are not limited to, physical therapists, registered nurses and licensed practical nurses.

Out-of-Pocket Maximum is the maximum amount of Deductible, Copayment and Coinsurance each individual or family incurs in Covered Expenses in a Year.

Participating Pharmacy/In-Network Pharmacy is a retail Pharmacy which We have contracted with to provide Prescription Drug services to Insured Persons or Our designated home delivery Pharmacy which We have contracted with to provide home delivery Prescription Drug services to Insured Persons.

Participating Provider/In-Network Provider means:

- Hospitals, Physicians, and Other Health Care Facilities or Professionals which are: (i) licensed in accordance with any applicable federal and state laws, (ii) satisfy the applicable credentialing criteria of Ours, including any required accreditations, and (iii) acting within the scope of the practitioner's license and accreditation, and have contracted with Us to provide services to Insured Persons; or
- For the purposes of reimbursement for Covered Expenses, an entity that has contracted with Us to arrange, through contracts with providers for the provision of any services and/or supplies, the charges for which are Covered Expenses.

This plan has a Tiered Network. Participating Providers under this plan may be part of a selected subset, or tier, of the Plan's entire network of Participating Providers. Providers may be classified as Tier 1 - (Enhanced Benefit) or Tier 2 - (Standard Benefit). In some cases, Your cost sharing (Copayment, Deductible and/or Coinsurance) will be lower for use of Tier 1 Providers, than for Tier 2 Providers. There are no referral requirements for any in-network provider regardless of tier. For services received as a result of an Emergency, if the Member is admitted to a Participating Hospital from the Emergency Room, the cost-sharing for inpatient care, including Medical Care provided by a Participating Professional Provider, will apply based on the tier level of each Provider rendering services.

Patient Protection and Affordable Care Act of 2010 (PPACA) is The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Pediatric Vision Care is vision care examinations and materials (frame and lenses) provided to an Insured Person through the end of the month in which the Insured Person turns 19 years of age. Please refer to the "Pediatric Vision Care" section of this Policy for additional details.

Pharmacy is a duly licensed pharmacy that dispenses Prescription Drugs or Related Supplies in a retail setting.

Pharmacy and Therapeutics (P&T) Committee is a committee comprised of both voting and non-voting clinicians that represent a range of clinical specialties. Consistent with applicable regulatory requirements, the P&T Committee regularly reviews Prescription Drugs and Related Supplies, including new Prescription Drugs and Related Supplies, for safety and efficacy; the findings of these clinical reviews enable the P&T Committee to make coverage status recommendations. The P&T Committee's review may be based on, for example, the U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed, English- language biomedical journals.

Physical and/or Occupational Therapy/Medicine is the therapeutic use of physical agents other than Prescription Drugs. It comprises the use of physical, chemical and other properties of heat, light, water, electricity, massage, exercise, spinal manipulation and radiation.

Policy is the set of benefits, conditions, exclusions, limitations, and Premiums described in this document, including the Policy specification page, the completed and accepted application for coverage, and any amendments or endorsements to this document.

Policyholder means the applicant who has applied for, been accepted for coverage, and who is named as the Policyholder on the specification page.

Premium means the sum of money paid periodically to Us by You in order for You and Your Family Members to receive the services and benefits covered by the Policy.

Prescription Drug is a drug, biologic (including a biosimilar), or other Prescription Drug that has been approved by the U.S. Food and Drug Administration (FDA), certain Prescription Drugs approved under the Drug Efficacy Study Implementation review, or Prescription Drugs marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or refill. This definition includes Generic Drugs, Brand Name Drugs, and Specialty Medications.

Prescription Drug Deductible means the amount of Covered Expenses that must be paid for Prescription Drugs and Related Supplies each Year before benefits for Prescription Drugs and Related Supplies are available under this Policy. The Prescription Drug Deductible does accumulate toward satisfying the Out-of-Pocket Maximum(s).

Formulary is a listing of covered Prescription Drugs and Related Supplies covered under Your Pharmacy Benefit. The Prescription Drugs and Related Supplies included in the Formulary have been approved in accordance with parameters established by the P&T Committee. The Formulary is regularly reviewed and updated. You can view the drug list at https://www.jeffersonhealthplans.com/individuals-families/

Prescription Order (Prescription) is the lawful authorization for a Prescription Drug or Related Supply by a Physician or other provider who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

Primary Care Physician (PCP) is a Physician who is credentialed by the Plan as a general practitioner, internist, family practitioner or pediatrician.

Prior Authorization means the approval for certain medical services or Prescription Drugs and Related Supplies that a Participating Provider must request and receive, from Us for medical services and from Us or the designated Pharmacy Benefit Manager for Prescription Drugs and Related Supplies, before the services are rendered, or the Prescription Drugs are dispensed, in order for those medical services or Prescription Drugs and Related Supplies to be eligible for benefits under this Policy. You can identify the Prescription Drugs and Related Supplies that require Prior Authorization on the Formulary at https://www.jeffersonhealthplans.com/individuals-families/

Prostheses/Prosthetic Appliances and Devices (Prosthetics) are artificial devices designed to replace wholly or partly, an arm or leg. Prostheses/Prosthetic Appliances and Devices include, but are not limited to:
- Basic limb Prostheses;
- Terminal devices such as hands or hooks.

Provider means a Hospital, a Physician or an Other Health Care Facility or Professional:
- Licensed in accordance with any applicable federal and state laws
- Accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another organization, if approved by Us, and
- Acting within the scope of the practitioner's license and accreditation; or
- An entity that directly or indirectly arranges, through contracts with other providers, for the provision of any Covered Services.

Reconstructive Surgery includes breast reconstruction incident to mastectomy or lumpectomy when performed as treatment for breast cancer to restore or achieve breast symmetry. This includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed.

Related Supplies are diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for self-injectable outpatient Prescription Drugs that are not dispensed in pre-filled syringes, inhalers, inhaler spacers for the management and treatment of pediatric asthma and other conditions, diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills); disposable needles and syringes needed for injecting covered drugs and supplements.

Self-administered Injectable Medications are FDA-approved medications for which the FDA does not require administration by a health care professional and are generally considered appropriate for a person to administer to himself/herself by means of intramuscular, intravenous or subcutaneous injection. This does not include insulin prescribed for use by the Insured Person.

Service Area means the area where We have a Participating Provider network for use by this Policy. To locate a provider who is participating in the network used by this Policy, call the toll-free number on the back of Your ID card, or check https://www.jeffersonhealthplans.com/individuals-families/ and click on "Find Care and Costs".

Skilled Nursing Facility is an Institution that provides continuous skilled nursing services. It must:
- Be an Institution licensed and operated pursuant to law, and
- Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician, and
- Provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.), and
- Maintain a daily medical record on each patient.

This definition excludes any home, facility or part thereof used primarily for rest; a home or facility primarily for the aged or for the treatment of a person with alcohol or substance use or dependency; a home or facility primarily used for the care and treatment of mental diseases or disorders or custodial or educational care.

Smoking Cessation Attempt means a course of treatment including 4 tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling); and one 90- day regimen of certain FDA-approved tobacco cessation medications (including Prescription medications and over-the-counter medications obtained with a Physician's Prescription; please see the No

Cost Preventive Care Drug List at https://www.jeffersonhealthplans.com/individuals-families/ for details).

Sound Natural Teeth are teeth that are stable, functional, free from decay and advanced periodontal disease, in good repair at the time of the Accidental injury or trauma, and are not man-made.

Specialty Medication is a pharmaceutical product, including Self-administered Injectable Medications and Infusion and Injectable Medications considered by Jefferson Health Plans to be a Specialty Medication based on meeting three or more of the following factors, subject to applicable law:

- Whether the Prescription Drug or pharmaceutical product is prescribed and used for the treatment of complex, chronic, life-threatening or rare conditions;
- Whether the Prescription Drug or pharmaceutical product has a high acquisition cost; and
- Whether the Prescription Drug or pharmaceutical product is subject to limited or restricted distribution, requires special handling, frequent dosing adjustments, and/or requires enhanced patient education, provider coordination or clinical oversight; and
- Dispensed by preferred Specialty pharmacy vendor.

A Specialty Medication may not possess all or most of the above listed characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug or medical pharmaceutical will be considered a Specialty Medication.

The fact that a drug is considered a Specialty Medication based on the above criteria does not necessarily determine the tier assignment of the Specialty Medication, or whether the Specialty Medication is covered under the Prescription Drug benefit or medical benefit of this Policy.

Splint is an appliance for preventing movement of joints or for the fixation of displaced or movable parts.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Step Therapy is a type of Prior Authorization. We may require an Insured Person to follow certain steps before covering some Prescription Drugs and Related Supplies, including Specialty Medications. We may also require an Insured Person to try similar Prescription Drugs and Related Supplies, including Specialty Medications that have been determined to be safe, effective, and more cost effective for most people that have the same condition as the Insured Person. The Prescription Drugs and Related Supplies that require Step Therapy can be identified on the Formulary at https://www.jeffersonhealthplans.com/individuals-families/

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. It causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Terminal Illness is an Illness in which a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Tribal Health Program means, with respect to an Insured Person who is a Native American or an Alaska Native only, an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service through, or provided for in, a contract or compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

Urgent Health Problem means a medical condition that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life (i.e., is not an Emergency Medical

Condition).

Virtual Care Service is a suite of medical Covered Services delivered through audio, video and secure internet-based technologies using real-time audio and video connectivity between a patient and a health care provider.

We/Us/Our is Jefferson Health Plans.

You, Your, and Yourself is the Policyholder who has applied for, and been accepted for coverage, and is named as the Policyholder on the specification page.

Who Is Eligible For Coverage?

Eligibility Requirements

You are eligible for coverage under this Policy if, at the time of application:

- You are a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and are reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought; and
- You are a resident of the state of Pennsylvania; and
- You live in the Enrollment Area in which You are applying, and intend to continue living there for the entire period for which enrollment is sought; and
- You are not incarcerated other than incarceration pending the disposition of charges; and
- You do not reside in an Institution; and
- You have submitted a completed and signed application for coverage and have been accepted in writing by Us.

You must notify Us of all changes that may affect any Insured Person's eligibility under this Policy. Other Insured Persons may include the following Family Member(s):

- Your lawful spouse or domestic partner who lives in the Enrollment Area.
- Your children who live in the Enrollment Area and have not yet reached age 26.
  - **Your own, Your spouse's** or Your domestic partner's **newborn children** are automatically covered for the first 31 days of life. To continue coverage past that time, You must enroll the child as a Family Member by applying for his or her enrollment as a Family Member within 60 days of the date of birth and pay any additional Premium for coverage beyond the 31st day after birth. Coverage for a newborn dependent child enrolled within 60 days of birth will be retroactive to the date of the child's birth.
  - An **adopted child,** including a child who is placed with You for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage past that time, You must enroll the child as a Family Member by applying for his or her enrollment as a Family Member within 60 days of the date of adoption and pay any additional Premium for coverage beyond the 31st day following placement of the child. Coverage for an adopted dependent child enrolled within 60 days of adoption will be retroactive to the date of the child's placement for adoption or initiation of a suit of adoption.
  - A child who is placed with You for **foster care** is automatically covered for 31 days from the date of the foster child's placement. To continue coverage past that time, You must enroll the foster child as a Family Member by applying for his or her enrollment as a dependent within 60 days of the date the child is placed with You for foster care and pay any additional Premium. Coverage for a foster child enrolled within 60 days of placement for foster care will be retroactive to the date of the child's placement for foster care.
  - **If a court has ordered a Policyholder to provide coverage for an eligible child** (as defined above) coverage will be automatic for the first 31 days following the date on which the court order is issued. To continue coverage past that time, You must enroll the child as a Family Member by applying for his or her enrollment as a Family Member within 60 days of the court order date and pay any additional Premium. Court-ordered coverage for a dependent child enrolled within 60 days of the court order will be retroactive to the date of the court order.

- Your **stepchildren** who live in the Enrollment Area and have not yet reached age 26.
- Your own, Your spouse's or Your domestic partner's **unmarried children**, regardless of age, enrolled prior to age 26, who are incapable of self-support due to medically certified continuing intellectual or physical disability, and are chiefly dependent upon the Insured Person for support and maintenance. We may require written proof of such disability and dependency within 31 days after the child's 26th birthday.
- Your eligible Family Members who return from active military service, once We receive the required form approved by the Department of Military & Veteran Affairs (DMVA), when the Family Member is: 1) a member of the Pennsylvania National Guard or any reserve component of the armed forces of the United States who is called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days; or 2) a member of the Pennsylvania National Guard ordered to active State duty, including duty relating to the Emergency Management Assistance Compact, for a period of 30 or more consecutive days.

NOTE: A child enrolled as a Family Member under this Policy who resides outside of the Service Area, is entitled to receive, while outside the Service Area, only Emergency Services for Emergency Medical Conditions.

When Can I Apply?

Application to Enroll or Change Coverage

The Patient Protection and Affordable Care Act of 2010 (PPACA) specifies that an eligible person must enroll for coverage or change plans during the Annual Open Enrollment Period. Persons who fail to enroll or change plans during the Annual Open Enrollment Period must wait until the next Annual Open Enrollment Period to enroll in a plan or to change plans. However, if a person experiences a triggering event as described below, the triggering event starts a 60-day special enrollment period during which an eligible person can enroll and an Insured Person can add dependents and change coverage.
The Annual Open Enrollment Period and special enrollment period are explained below.

Annual Open Enrollment Period

The Annual Open Enrollment Period is a specified period each Year during which individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another.

To be enrolled for coverage under this Policy, You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible dependent(s), and We must receive that application during the Annual Open Enrollment Period.

Your coverage under this Policy will then become effective upon the earliest day allowable under federal rules for that Year's Annual Open Enrollment Period. **Note: If You do not apply to obtain or change coverage during the Annual Open Enrollment Period, You will not be able to apply again until the following Year's Annual Open Enrollment Period** unless You qualify for a special enrollment period as described below.

Special Enrollment Periods

A special enrollment period occurs when a person experiences a triggering event.
If You experience one of the triggering events listed below, You can enroll for coverage and enroll Your eligible dependent(s) during a special enrollment period instead of waiting for the next Annual Open Enrollment Period.

Triggering events for a special enrollment period OFF Marketplace are:

- An eligible individual, and any dependent(s), loses his or her minimum essential coverage; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gaining or becoming a dependent through marriage (NOTE: special enrollment for marriage only applies if at least one spouse was enrolled in an exchange plan at least 1 day in the 60 days before marriage; or lived abroad for 1 or more days in the 60 days before marriage; or is an American Indian or Alaska Native), birth, adoption, placement for adoption, placement for foster care, or through a child support order or other court order; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan (QHP) is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the Premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. The Marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to a new QHP as a result of a permanent move (including a move outside the Enrollment Area of the individual's current plan); or
- An eligible individual newly gains access to an employer-sponsored individual coverage health reimbursement account (ICHRA); or
- An eligible individual newly gains access to a qualified small employer health reimbursement arrangement (QSEHRA).

Triggering events **do not** include loss of coverage due to failure to make Premium payments on a timely basis, including COBRA Premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will have coverage Effective Dates determined as follows:

- In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care; or
- In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, coverage is effective for a qualified individual or enrollee on the first day of the following month.

For all other triggering events, the Effective Dates are:

- For an application made between the first and the 15th day of any month, the Effective Date of coverage will be the first day of the following month; or
- For an application made between the 16th and the last day of the month, the Effective Date of coverage will be the first day of the second following month.

Triggering events for a special enrollment period ON Marketplace are:

- An eligible individual, and any dependent(s), loses his or her minimum essential coverage, pregnancy-related Medicare/Medicaid coverage, or medically needy coverage (only once per Calendar Year), or the qualified individual or dependent is enrolled in any non-Calendar Year group or individual health insurance coverage (even if they have the option to renew such coverage). The date of the loss of minimum essential coverage, pregnancy-related coverage, or medically needy coverage is the last day the individual would have coverage under the plan. The date of loss of non-Calendar Year insurance is the last day of the plan or policy year; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gaining or becoming a dependent through marriage (NOTE: special enrollment for marriage only applies if at least one spouse was enrolled in an exchange plan at least 1 day in the 60 days before marriage; or lived abroad for 1 or more days in the 60 days before marriage; or is an American Indian or Alaska Native), birth, adoption, placement for adoption, placement for foster care, or through a child support order or other court order; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee; or
- An eligible individual, or his or her dependent, who has purchased an off-Marketplace plan who experiences a decrease in household income; is newly determined eligible for APTC; and had minimum essential coverage for one or more days during the 60 days preceding the date of the financial change; or
- At the option of the Marketplace, the enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation, or if the enrollee or his or her dependent dies; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- A qualified individual or dependent becomes newly eligible for enrollment in a QHP when they satisfy the Marketplace's citizenship requirement or are released from incarceration; or
- An eligible individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Marketplace that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the Premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan:

The enrollee or dependent is determined newly eligible or ineligible for the advanced Premium tax credit (APTC) or has a change in eligibility for cost-sharing reductions;
A qualified individual or his or her dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC based in part on a finding that such individual is ineligible for qualifying coverage in an eligible employer-sponsored plan, including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage;
A qualified individual who was previously ineligible for APTC because of a household income below 100% of the federal poverty level (FPL) and who was also ineligible for Medicaid because he or she was living in a non-Medicaid expansion state, either experiences a change in income or moves to a different state, making them newly eligible for APTC.

- The Marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to a new QHP as a result of a permanent move (including a move outside the Enrollment Area of the individual's current plan) and either (1) had minimum essential coverage for one or more days during the 60 days preceding the date of the move, or (2) was living outside of the United States; or
- The qualified individual who gains or maintains status as an Indian or an Alaska Native, as defined by section 4 of the Indian Health Care Improvement Act (or their dependent), may enroll in a qualified health plan or change from one qualified health plan to another one time per month; or
- An eligible individual or enrollee demonstrates to the Marketplace, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the Marketplace may provide; or a qualified individual (or their dependent) who is enrolled in minimum essential coverage and is a victim of domestic abuse or spousal abandonment seeks to enroll in coverage separate from the perpetrator; or
- A qualified individual or dependent applies for Marketplace or Medicaid or CHIP coverage during open enrollment or due to a qualifying life event, but is determined ineligible for Medicaid or CHIP after the exchange Annual Open Enrollment Period has ended or more than 60 days after a qualifying life event; or
- The qualified individual or enrollee (or their dependent) adequately demonstrates to the Marketplace that a material error related to plan benefits, Service Area or Premium influenced their decision to purchase a QHP; or
- At the option of the Marketplace, the qualified individual provides satisfactory evidence to verify eligibility for an insurance affordability program or enrollment in a QHP following termination of exchange enrollment due to a failure to verify such status within established time periods, or is under 100% of the federal poverty level and did not enroll in coverage while waiting for HHS to verify citizenship, status as a national or lawful presence; or
- An eligible individual newly gains access to an employer-sponsored individual coverage health reimbursement account (ICHRA); or
- An eligible individual newly gains access to a qualified small employer health reimbursement arrangement (QSEHRA).

Triggering events do not include loss of coverage due to failure to make Premium payments on a timely basis, including COBRA Premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will have coverage Effective Dates determined as follows:

- In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care; or
- In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, coverage is effective for a qualified individual or enrollee on the first day of the following month; or
- In the case of untimely notice of a triggering event, the exchange must provide the earliest Effective Date that would have been available based on the applicable triggering event.

For all other triggering events the Effective Dates are:

- For an application made between the first and the 15th day of any month, the Effective Date of coverage will be the first day of the following month; or
- For an application made between the 16th and the last day of the month, the Effective Date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

Except as described in the Continuation section, an Insured Person **will become ineligible for coverage** under the Policy:

- When Premiums are not paid according to the due dates and grace periods described in the Premium section.
- For the spouse - when the spouse is no longer married to You.
- For You and Your Family Member(s) - when You no longer meet the requirements listed in the Eligibility Requirements section.
- The date the Policy terminates.
- When the Insured Person no longer lives in the Enrollment Area.

Remember, it is Your responsibility to notify Us immediately of any changes affecting You or any of Your Family Member(s') eligibility for benefits under this Policy.

Continuation

If an Insured Person's eligibility under this Policy would terminate due to the Policyholder's death, divorce or if other Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Policy, except for the Policyholder's failure to pay Premium, that Family Member has the right to continuation of his or her insurance. Coverage will be continued if the Family Member exercising the continuation right notifies Us and pays the appropriate monthly Premium within 60 days following the date this Policy would otherwise terminate. In such a case, coverage will continue without evidence of insurability.

How the Policy Works

Note: Services performed by a Non-Participating (an Out-of-Network) Provider are not covered under this Policy except for Emergency Services.

Benefit Schedule

The benefit schedule shows the Individual and Family Deductible and Out-of-Pocket Maximums, and the maximum Covered Expense for each type of benefit.

No benefits are payable unless the Insured Person's coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms, conditions, limitations and exclusions of this Policy.

Participating Hospitals, Participating Physicians and Other Participating Providers

Covered Expenses for services provided by Participating Providers are based on Our Negotiated Rate. Participating Providers have agreed **NOT** to balance bill Members for Covered Services beyond the Member cost share amounts set forth in the Policy. Participating Providers may charge the Insured Person for services that are not Covered Services under the Policy. In addition, Participating Providers will file claims with Us for the Insured Person and will request Prior Authorization when it is required.

Be sure to check with the provider prior to an appointment to verify that the provider is currently contracted with Us.

Non-Participating Hospitals, Non-Participating Physicians, and other Non-Participating Providers

Covered Expenses for services provider by Non-Participating Providers are based on a reasonable amount determined by the health plan using industry standards. Non-Participating Providers can balance bill Members for the difference between the Covered Expense paid by the Plan and the actual amount billed. Non-Participating Providers may charge the Insured Person for services that are not Covered Services under the Policy. For Covered Services received from a Non-Preferred Provider, payment will be made directly to the Covered Person and the Covered Person will be responsible for reimbursing the Non-Preferred Provider. However, the Carrier reserves the right, in its sole discretion, to make payments directly to the Non-Preferred Provider.

Special Circumstances

This Policy will provide benefits at the In-Network level for Non-Participating Providers in the limited situations described below. Your cost-sharing for Covered Expenses incurred for the services of a Non-Participating Provider in these special circumstance is indicated in the benefit schedule:

- **Emergency Services**
  - Covered Expenses incurred for the treatment of an Emergency Medical Condition provided in the emergency department of a Non-Participating Hospital or of a licensed outpatient emergency department are paid as described in the benefit schedule. Any additional expenses incurred for services of a Non-Participating Provider after the patient is Stabilized and his/her condition permits transfer to a Participating Hospital and/or to the care of a Participating Physician are not covered at the out-of-network benefit level, except as stated in the Other Circumstances section below. For such Covered Services, the Health Benefit Plan will reimburse the Non-Participating Hospital-Based provider based upon the methodology established by the Consolidated

Appropriations Act (CAA). The Member is protected from surprise billing, cannot be balanced billed, and will be subject to the in-network cost-sharing levels by the Non-Participating Hospital-Based provider, and the Non-Participating Hospital-Based provider cannot ask the Member to give up their protections not to be balanced billed. If the Member receives other services at a Participating Hospital or other Participating Facility provider, Non-Participating Providers cannot balance bill the Member, unless the Member gives written consent and gives up the protections not to be balanced billed.

- **Hospital-Based Provider**
  - When You receive Covered Services from a Hospital-Based provider (including anesthesiologists, radiologists, pathologists and other ancillary providers) while You are an Inpatient at a Participating Hospital or receiving outpatient Covered Services at a Participating Facility provider (i.e., Hospital outpatient department or ambulatory surgical center) provider and are being treated by a Participating Professional provider, You will receive benefits for the Covered Services provided by the Non-Participating Hospital-Based provider. For such Covered Services, the Health Benefit Plan will reimburse the Non-Participating Hospital-Based provider based upon the methodology established by the Consolidated Appropriations Act (CAA). The Member is protected from surprise billing, cannot be balanced billed, and will be subject to the in-network cost-sharing levels by the Non-Participating Hospital-Based provider, and the Non-Participating Hospital-Based provider cannot ask the Member to give up their protections not to be balanced billed. If the Member receives other services at a Participating Hospital or other Participating Facility provider, Non-Participating Providers cannot balance bill the Member, unless the Member gives written consent and gives up the protections not to be balanced billed.

- **Other Circumstances**
  - Covered Expenses for non-emergency, Medically Necessary services of a Non-Participating Provider will be paid according to the Participating Provider Cost Share shown in the benefit schedule in the following cases:
    - When reasonable and appropriate treatment of the disease, illness or injury present is unavailable from a Participating Provider, or
    - For any other reason We determine, based on the unique fact pattern present that it is reasonable to receive services from a Non- Participating Provider.

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before this Policy will pay Your claims. Deductibles apply to all Covered Expenses as described in the “Definitions” section of this Policy, unless expressly stated otherwise in the benefit schedule. Deductibles do not include any amounts in excess of the Allowed Expense, any penalties, or expenses that are not Covered Expenses.

Deductibles will be applied in the order in which an Insured Persons claims are received and processed by Us, not necessarily in the order in which the Insured Person received the service or supply.

Deductible

The Deductible is stated in the benefit schedule. The Deductible is the amount of Covered Expenses You must pay for **any** Covered Services (except as specifically stated otherwise in the benefit schedule) incurred from Participating Providers each Year before this Policy will pay Your claims. There are two ways an Insured Person can meet his or her Deductible:

- When an Insured Person meets his or her Individual Deductible, that Insured Person’s benefits will be paid accordingly, whether any applicable Family Deductible is satisfied or not.

- If one or more Family Members are enrolled for coverage under this Policy, the Family Deductible will apply. Each Insured Person can contribute up to the Individual Deductible amount toward the Family Deductible. Once this Family Deductible is satisfied, no further Individual or Family Deductible is required for the remainder of that Year.

Prescription Drug Deductible

A Prescription Drug Deductible, separate from the Deductible shown on the first page of the benefit schedule, may apply each Year only to Prescription Drugs and Specialty Medications covered by this Policy. Please refer to the definitions of "Individual Prescription Drug Deductible" and "Family Prescription Drug Deductible." The Prescription Drug Deductible is shown in the Prescription Drug Benefits section of the benefit schedule.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the maximum amount of Deductible, Copayment and Coinsurance each Family Member incurs in Covered Expenses in a Year.

- The Individual Out-of-Pocket Maximum is an accumulation of Covered Expenses. It includes Deductibles, Copayments and Coinsurance for medical and Prescription Drug Covered Services. Once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services, You will no longer have to pay any Coinsurance or Copayment for medical or Pharmacy services for Covered Expenses incurred during the remainder of that Year. Non-compliance penalty charges do not apply to the Individual Out-of-Pocket Maximum and will always be paid by You. The amount of the Individual Out-of-Pocket Maximum is described in the benefit schedule section of this Policy.
- The Family Out-of-Pocket Maximum applies if You have a family plan and You and one or more of Your Family Member(s) are enrolled for coverage under this Policy. It is an accumulation of the Individual Covered Expenses, including Deductibles, Copayments and Coinsurance for medical and Prescription Drug Covered Services, paid by each Family Member for Covered Expenses during a Year. If You cover other Family Member(s), each Insured Person's Covered Services accumulate toward the Family Out-of-Pocket Maximum. Each Insured Person can contribute up to the Individual Out-of-Pocket amount toward the Family Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum for In-Network Covered Services has been met, the Family Members will no longer have to pay any Deductible, Coinsurance or Copayments for Covered Expenses incurred In-Network during the remainder of that Year. The amounts of the Individual and the Family Out-of-Pocket Maximum are described in the benefit schedule section of this Policy.

Special Limits

There may be limits applied to certain Covered Services in the form of an Annual maximum on the number of visits, days or events the Policy will cover for a specific type of service. The expenses You incur which exceed specific maximums described in this Policy will be Your responsibility. Any special limits applicable to benefits in this Policy are described in the benefit schedule.

The expenses You incur which exceed specific maximums described in this Policy will be Your responsibility.

Penalties

A penalty is an amount of Covered Expenses that is:

- Not counted toward any Deductible;
- Not counted toward the Out-of-Pocket Maximum; and
- Not eligible for benefit payment once the Deductible is satisfied.

The following services require Prior Authorization. Penalties may be assessed against Your provider if Your provider fails to obtain Prior Authorization:

- Inpatient Hospital admissions and all other facility admissions.
- Certain outpatient surgeries and diagnostic procedures.
- Certain Durable Medical Equipment items.
- Certain Home Nursing Services.
- Certain Air Ambulance.
- Certain Diagnostic Imaging Services.
- Certain Implantable devices.
- Certain infusion and injectable drugs.

Penalties are applied before this Policy pays claims.

Comprehensive Benefits: What the Policy Pays For

Please refer to the benefit schedule for additional benefit provisions which may apply to the information below.

To be eligible for benefits under this Policy, the provider must be appropriately licensed according to state and local laws and accredited to provide services within the scope of the provider's license and accreditation.

Before this Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You satisfy the appropriate Deductibles, We will begin paying for Covered Services as described in this section. Some services, including preventive care, are not subject to any Deductibles.

The benefits described in this section will be paid for Covered Expenses incurred on the date You and Your Family Member(s) receive the service or supply for which the Charge is made. These benefits are subject to all terms, conditions, Deductibles, penalties, exclusions, and limitations of this Policy. All services will be paid at the percentage or copayment indicated in the benefit schedule and subject to limits outlined in the section entitled "How the Policy Works."

The following is a general description of the supplies and services for which the Policy will pay benefits if such services and supplies are Medically Necessary and for which You are otherwise eligible as described in this Policy.

Note: Services from an Out-of-Network (Non-Participating) Provider are not covered except for Emergency Services or when received from an ancillary provider at an In-Network Facility.

If You are inpatient in a Hospital or Other Health Care Facility on the day Your coverage begins, We will pay benefits for Covered Services that You receive on or after Your first day of coverage related to that inpatient stay as long as You receive Covered Services in accordance with the terms of this Policy. These benefits are subject to any prior carrier's obligations under state law or contract.

Abortion Services

This Policy provides benefits for Covered Expenses for termination of a pregnancy limited to those necessary to prevent the death of the woman, or to terminate a pregnancy caused by rape or incest. Covered Expenses include:

- Physician Services.
- Outpatient facility charges.
- Outpatient services and supplies.

Ambulance Services

This Policy provides benefits for Medically Necessary Covered Expenses incurred for the following ambulance services:

- Base Charge, mileage and non-reusable supplies of a licensed ambulance company for transportation to and from an Inpatient confinement at a Hospital or Skilled Nursing Facility within the covered Service Area.
- Monitoring, electrocardiograms (EKGs or ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriate licensed person must render the services.
- Ambulance transportation for emergency situations, to the nearest facility capable of handling the emergency.

This coverage includes Medically Necessary transport by air and/or water ambulance when:

- The point of pickup is not accessible by ground ambulance;
- Ground ambulance transport is not feasible due to the distance to the nearest Hospital capable of handling the patient’s Illness or Injury or other obstacles to ground transport; or
- The time required for ground ambulance transport would impede timely and appropriate medical care.

Autism Spectrum Disorders

This Policy provides benefits for Covered Expenses for Insured Persons for Charges made for:

- Diagnosis of Autism Spectrum Disorders; and
- Treatment of Autism Spectrum Disorders.

Treatment for Autism Spectrum Disorders shall include the following care prescribed, provided, or ordered for an individual diagnosed with an Autism Spectrum Disorder by

- A Physician licensed to practice medicine in all its branches or
- A certified, registered, or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a Physician licensed to practice medicine in all its branches.

Except for inpatient services, upon request from Us and not more than once every 12 months, a provider of treatment for Autism Spectrum Disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is Medically Necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, We may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

Covered Services include:

- Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
- Psychological care, meaning direct or consultative services provided by a licensed psychologist.
- Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including Applied Behavior Analysis, that are intended to develop, maintain, and restore the functioning of an individual.
- Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:
  - Self-care and feeding;
  - Pragmatic, receptive, and expressive language;
  - Cognitive functioning;
  - Applied Behavior Analysis, intervention, and modification;
  - Motor planning; and;
  - Sensory processing.

Clinical Trials

Benefits are payable for all routine patient care costs related to an approved clinical trial provided by a Participating Provider, including Phases I through IV, for an Insured Person who meets the following requirements:

1. Is eligible to participate in an approved clinical trial according to the trial protocol with respect to the prevention, detection and treatment of cancer or other life-threatening disease or condition and
2. Either:
   a. The referring health care professional is a participating health care Provider and has concluded that the Insured Person’s participation in such trial would be appropriate based

upon the Insured Person meeting the conditions described in paragraph (1); or
   b. The Insured Person provides medical and scientific information establishing that the Insured Person's participation in such a trial would be appropriate based upon the Insured Person - meeting the conditions described in paragraph (1).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of premature death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet one of the following requirements:

1. Be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials:
   a. An institute or center of the National Institutes of Health,
   b. The Food and Drug Administration,
   c. The Department of Veterans Affairs,
   d. The Department of Defense,
   e. The Department of Energy,
   f. The Centers for Disease Control and Prevention,
   g. The Agency for Health Care Research and Quality,
   h. The Centers for Medicare & Medicaid Services,
   i. Cooperative group or center of any of the entities described in clauses (a) through (f) or the Department of Defense or the Department of Veterans Affairs, or
   j. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
2. Be conducted under an Investigational new drug application reviewed by the Food and Drug Administration; or
3. Involve a drug trial that is exempt from having such an Investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services typically covered by Us for an Insured Person who is not enrolled in a clinical trial, including the following:

- Services typically provided absent a clinical trial.
- Services generally required to diagnose, treat or ameliorate the medical condition present and not solely for the provision of the Investigational drug, item, device or service.
- Services required to diagnose, treat or ameliorate the medical condition present and not for the monitoring of the Investigational drug, device, item or service.
- Services required to diagnose, treat or ameliorate the medical condition present and not for the prevention of complications arising from the provision of the Investigational drug, device, item or service.
- Reasonable and necessary care arising from the provision of the Investigational drug, device, item or service, including the diagnosis or treatment of unanticipated complications.

For clinical trials, routine patient costs **do not** include:

- The Investigational item, device, or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Consumable Medical Supplies

This Policy provides benefits for Covered Expenses incurred for purchase of Consumable Medical Supplies when:

- It is used in the Member's home; and
- It is obtained through a Participating Durable Medical Equipment provider
- It is prescribed by an eligible provider
- The FDA has determined that a prescription from a licensed health care professional is required in order to dispense the supply
- And such supply is not intended to withstand repeated use

Day Rehabilitation

Covered Service will be provided for a Day Rehabilitation Program when provided by a Participating Facility provider under the following conditions:

- The Member requires intensive Therapy Services, such as Physical, Occupational and/or Speech Therapy five (5) days per week;
- The Member has the ability to communicate verbally or non-verbally, the ability to consistently follow directions and to manage their own behavior with minimal to moderate intervention by professional staff;
- The Member is willing to participate in a Day Rehabilitation Program;
- The Member's family must be able to provide adequate support and assistance in the home and must demonstrate the ability to continue the rehabilitation program in the home.

Dental Care

This Policy provides benefits for dental care for an accidental Injury to sound natural teeth, subject to the following:

- Services must be received during the 6 months following the date of Injury;
- No benefits are available to replace or repair existing Dental Prostheses even if damaged in an eligible accidental Injury; and
- Damage to natural teeth due to chewing or biting is not considered an accidental Injury under this Policy.

Anesthesia for Dental Procedures

This Policy provides benefits for general anesthesia and medical care facility charges for dental care provided the Insured Person:

- Is a child 7 years of age or under;
- Is severely disabled; or
- Has a medical or behavioral condition which requires hospitalization or general anesthesia for dental care.

Diabetes

Covered Services for Diabetes are covered on the same basis as any other medical condition. This Policy provides benefits for Covered Expenses including outpatient Diabetic Self-Management Training and education, Diabetic Equipment and Diabetic Pharmaceuticals and Supplies for the treatment of Type I Diabetes, Type 2 Diabetes, and Gestational Diabetes Mellitus.

Diagnostic Services

For any eligible condition, this Policy provides indicated benefits for Covered Expenses for:

- Routine Diagnostic Services, such as routine radiology (consisting of x-rays, mammograms, ultrasound and nuclear medicine), routine medical procedures (consisting of Electrocardiogram

(ECG), Electroencephalogram (EEG), and other diagnostic medical procedures approved by the PPO).

- Non-Routine Diagnostic Services, such as Nuclear Cardiology Imaging, Magnetic Resonance Imaging/Magnetic Resonance Angiography (MRI/MRA), Positron Emission Tomography (PET Scan),Sleep Studies, and Computed Tomography (CT Scan).

Durable Medical Equipment

This Policy provides benefits for Covered Expenses incurred for rental or purchase of medical equipment and/or supplies that meet all of the following requirements:

- Are ordered by a Physician;
- Serve a medical purpose and are expected to be of no further use when medical need ends;
- Are not primarily for comfort or hygiene;
- Are not for environmental control;
- Are not for exercise; and
- Are manufactured specifically for medical use.

Note: Medical equipment and supplies must meet all of the above requirements in order to be eligible for benefits under this Policy. The fact that a Physician prescribes, or orders equipment or supplies does not necessarily qualify the equipment or supply for payment. Coverage for Durable Medical Equipment is limited to the most cost-effective alternative.

We determine whether the item meets these conditions and whether the equipment falls under a rental or purchase category.

Rental Charges that exceed the reasonable purchase price of the equipment are not covered, unless the equipment has previously been determined by Us to fall into a continuous rental category and requires frequent maintenance and servicing.

Coverage for repair, replacement or duplicate equipment is provided only when approved as Medically Necessary. All maintenance and repairs that result from an Insured Person’s misuse are the Insured Person’s responsibility.

External Prosthetic Appliances and Devices

This Policy provides benefits for Covered Expenses made or ordered by a Physician for the initial purchase and fitting of external Prosthetic Appliances and Devices available only by prescription which are Medically Necessary for the alleviation or correction of Illness, Injury, or congenital defect.

External Prosthetic Appliances and Devices include Prostheses/Prosthetic Appliances and Devices; Orthoses and Orthotic Devices; Braces; and Splints.

Coverage for external Prosthetic Appliances and Devices is limited to the most appropriate and cost-effective alternative. This includes coverage for repair, maintenance or replacement of a covered Prosthetic Appliance or Device, unless replacement is required because of misuse or loss of the Prosthetic on the part of the Insured Person.

Coverage is provided for custom foot Orthoses and other Orthoses.

Only the following non-foot Orthoses are covered, when Medically Necessary:

- Rigid and semi-rigid custom fabricated Orthoses;
- Semi-rigid prefabricated and flexible Orthoses; and

- Rigid prefabricated Orthoses, including preparation, fitting and basic additions, such as bars and joints.

Custom foot Orthotics are only covered when Medically Necessary, as follows:

- For Insured Persons with impaired peripheral sensation and/or altered peripheral circulation (e.g., diabetic neuropathy and peripheral vascular disease);
- When the foot Orthosis is an integral part of a leg Brace, and it is necessary for the proper functioning of the Brace;
- When the foot Orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputation) and is necessary for the alleviation or correction of Illness, Injury, or congenital defect; and
- For Insured Persons with a neurologic or neuromuscular condition (e.g., cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot, and there is reasonable expectation of improvement.

Coverage for replacement of external Prosthetic Appliances and Devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the Insured Person will not be covered; and
- Replacement will be provided when anatomic change has rendered the external Prosthetic Appliance or Device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Emergency Care

Your Plan provides coverage for medical emergencies. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

In-Network Benefits for Eligible Expenses for Emergency Care, including Emergency Care for Behavioral Health Services, will be determined as shown on Your Schedule of Benefits. If admitted for the emergency condition immediately following the visit, the Copayment Amount for the Emergency Room visit will be waived. If admitted for the emergency condition immediately following the visit, Preauthorization of the inpatient Hospital admission will be required, and inpatient Hospital coverage will apply.

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the provider is a Network provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Foreign Country Providers

This Policy provides benefits for Covered Expenses for services and supplies received from foreign country providers for medical emergencies and other urgent and not reasonably anticipated situations where treatment could not have been reasonably delayed until the Insured Person was able to return to the United States.

We do not accept assignment of benefits from foreign country providers and do not cover the cost of repatriation to the US for either emergency care or ongoing care after stabilization. You and Your family members can file a claim with Us for services and supplies from a Foreign Country Provider but any payment will be sent to You. You are responsible for paying the Foreign Country Provider. You, at Your expense is responsible for obtaining an English language translation of foreign country Provider claims and any medical records that may be required. Benefits are subject to all terms, conditions, limitations, penalties and exclusions of this Policy and will not be more than would be paid if the service or supply had been received in the United States.

Habilitative Services

This Policy provides benefits for Covered Expenses designed to assist You in developing a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame and are payable as stated in the benefit schedule.

This Policy provides benefits for Covered Expenses incurred for the following Habilitative Services:

- Therapeutic use of heat, cold, exercise, electricity or ultraviolet light;
- Manipulation of the spine;
- Massage, to improve circulation, strengthen muscles, encourage return on range of motion, as part of treatment for an Illness or Injury;
- Services for the necessary care and treatment of loss or impairment of speech; and
- Services designed to assist a child to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame.

Benefits are provided up to any maximum number of visits shown in the benefit schedule. For the purposes of this benefit, the term "visit" includes any outpatient visit to a Physician during which one or more Covered Services are provided.

All supplies and additional fees charged in conjunction with these services will be included in the payment of benefits for the visit and will not be reimbursed in addition to the visit.

Home Health Care Services

This Policy includes benefits for Covered Expenses for home health services when You: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility. Home health services are provided only if We have determined that the home is a medically appropriate setting.

Home health services are those skilled health care services that can be provided during visits by Other Health Care Professionals, including Medically Necessary services of a medical social worker. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Necessary consumable medical supplies and home infusion therapy administered or used by providers in providing home health services are covered. Home health services do not include services by a person who is a member of Your family or Your dependent's family, or who normally resides in Your house or Your dependent's house even if that person is a provider. Skilled nursing services or private duty nursing services provided in the home are subject to the home health services benefit terms, conditions and benefit limitations.

This Policy provides benefits for Covered Expenses for home health care prescribed by the Physician treating Your condition when the following criteria are met:

- The care described in the plan of care must be for intermittent skilled nursing, or Physical, Occupational, and other short-term rehabilitative therapy services.
- The Insured Person must be confined at home, in lieu of hospitalization, under the active supervision of a Physician.
- The home health agency delivering care must be certified within the state where the care is received.
- The care that is being provided is not Custodial Care.

The Physician must be treating the Illness or Injury that necessitates home health care. **Home health services are limited to any combined maximum number of visits each Year as shown in the benefit schedule**.

If the Insured Person is a minor or an adult who is dependent upon others for non-skilled care, Custodial Care and/or activities of daily living (e.g., bathing, eating, etc.), home health care will be covered only during times when there is a family member or care giver present in the home to meet the Insured Person's non-skilled care and/or Custodial Care needs.

Hospice Services

This Policy provides benefits for Covered Expenses for Hospice Care Services under a Hospice Care Program for Insured Persons who have a Terminal Illness and for the families of those persons, including palliative and supportive medical, nursing and other health services through home or inpatient care.

To be eligible for this benefit, the Hospice Care Services provider must be appropriately licensed according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of Terminal Illness. The provider must also be approved as a Hospice Care Services provider under Medicare and the Joint Commission on Accreditation of Health Care Organizations or by the appropriate agency of the state in which this Policy is sold.

To be eligible for benefits for a Hospice Care Program, the Insured Person must be suffering from a Terminal Illness, as certified by his or her Physician, notice of which is submitted to Us in writing.

The Physician must consent to the Hospice Care Program and must be consulted in the development of the treatment plan.

Injectable Medications

This Policy provides benefits for injectable medications required in the treatment of an injury or illness administered by a Participating Professional provider. This includes:

- **Standard Injectable Drugs**: Medication that is injectable or infusible but is not defined by the PPOO to be a Self-Administered Prescription Drug or Specialty Drug. Standard Injectable Drugs include, but are not limited to: allergy injections and extractions and injectable medications such as antibiotics and steroid injections that are administered by a Participating Professional provider.
- **Specialty Drug Injections:** Medication that is ordered or prescribed by a Physician and required by the Federal Drug Administration to be administered under the direct supervision of a healthcare professional. Such Specialty Medications may require Prior Authorization or Step Therapy.

Infertility Services

This Policy provides benefits for Covered Expenses incurred for the following services, including x-ray and laboratory:

- Services for diagnosis and treatment of involuntary infertility; and
- Artificial Insemination, with accompanying: simple sperm preparation; sperm washing; and/or thawing.

Inpatient Hospital Services, Supplies and Medical Care

For any eligible condition, this Policy provides indicated benefits for Covered Expenses for:

- Inpatient services and supplies provided by the Hospital except private room Charges above the prevailing two-bed room rate of the facility.
- Diagnostic/therapeutic lab and x-rays.
- Anesthesia and Inhalation therapy.

Payments of Inpatient Covered Expenses are subject to these conditions:

- Services must be those which are regularly provided and billed by the Hospital
- Services are provided only for the number of days required to treat the Insured Person’s Illness or

Injury.

Note: No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Inpatient Services at Other Health Care Facilities including Skilled Nursing Facilities

For any eligible condition, this Policy provides indicated benefits for Covered Expenses for inpatient services and supplies provided by an Other Health Care Facility, except private room Charges above the prevailing two-bed room rate of the facility. Payment of benefits for Other Health Care Facility services is subject to all of the following conditions:

- The Insured Person must be referred to the Other Health Care Facility by a Physician.
- Services must be those which are regularly provided and billed by an Other Health Care Facility.
- The services must be consistent with the Illness, Injury, degree of disability and medical needs.
- Benefits are provided only for the number of days required to treat the Illness or Injury, subject to any maximum number of covered days per Year shown in the benefit schedule.
- Services covered under this benefit cannot be provided in a less intense setting, such as outpatient services provided at home.
- The Insured Person must remain under the active medical supervision of a Physician treating the Illness or Injury for which he or she is confined in the Other Health Care Facility.

Note: No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Laboratory and Pathology Tests

This Policy provides benefits for Medically Necessary laboratory and pathology services.

Mastectomy and Related Procedures

This Policy provides benefits for Covered Expenses for Hospital and professional services under this Policy for mastectomy and lymph node dissection for the treatment of breast cancer and for the treatment of physical complications of all stages of mastectomy, including lymphedemas, when performed related to treatment of breast cancer, whether or not the mastectomy occurred while the Insured Person was covered under this Policy. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer.

If the Insured Person elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses.

Coverage for reconstructive breast surgery will not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the Policy definition of “Medically Necessary.” Benefits will be payable on the same basis as any other Illness or Injury under the Policy.

Medical Care

Medical Care rendered by a Participating Professional provider, including a Physician or Surgeon, who provides services to the Member while an Outpatient in a Participating Facility provider for services related to Surgery or other ambulatory patient services.

Medical Foods and Nutritional Formulas

This Policy provides benefits for Covered Expenses for Medically Necessary nutritional supplements or formulas as administered under the direction of a Physician for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

Mental Health and Substance Use Disorder Services

This Policy provides benefits for Covered Services as indicated below for inpatient and outpatient evaluation and treatment of Mental Health and Substance Use Disorders. Mental Health and Substance Use Disorder services that are not covered by this Policy are listed in the "Exclusions and Limitations: What Is Not Covered by This Policy" section.

Inpatient Services
Benefits include Covered Services provided by a Hospital for the evaluation and treatment of Mental Health and/or Substance Use Disorder during an inpatient admission for acute care for conditions such as:

- A patient who presents a danger to self or others;
- A patient who is unable to function in the community;
- A patient who is critically unstable;
- A patient who requires acute care during detoxification; and
- The diagnosis, evaluation and acute treatment of addiction to alcohol and/or drugs.

Benefits also include Covered Services provided by a Mental Health or a Substance Use Disorder Residential Treatment Center for an Insured Person who is confined in a Hospital or a Mental Health or Substance Use Disorder Treatment Residential Treatment Center as a registered bed patient, upon the recommendation of a Physician. Covered Services include hospitalization and residential treatment services provided by a Hospital or a Mental Health or Substance Use Disorder Residential Treatment Facility for the evaluation and treatment of psychological and social disturbances resulting from a subacute Mental Health or Substance Use Disorder condition that prevents an Insured Person from participating in treatment within the community and/or requires rehabilitation.

Outpatient Services
Benefits include Covered Services by Participating Providers who are qualified to treat Mental Health or Substance Use Disorders, when treatment is provided on an outpatient basis for treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal thinking; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention), outpatient testing, and assessment, Applied Behavior Analysis and medication management when provided in conjunction with a consultation. Covered Services include:

- Treatment of mental health conditions in an individual, family, group, partial hospitalization or intensive outpatient therapy setting.
- Treatment of abuse or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual, family, group, partial hospitalization or intensive outpatient therapy setting.
- Intensive outpatient structured therapy programs that consist of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health or Substance Use Disorder program. Intensive outpatient structured therapy programs provide a combination of individual, family and/or group therapy totaling 9 or more hours in a week.
- Mental Health or Substance Use Disorder partial hospitalization services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health or Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

Organ and Tissue Transplants and Related Specialty Care

Coverage is provided for human organ and tissue transplant services. This coverage is subject to the following conditions and limitations.

Coverage is provided for both the recipient and donor of a covered transplant under the recipient's plan.

Coverage will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant surgery. Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestinal, including small bowel/liver or multivisceral.
- The evaluation, preparation and delivery of the donor organ.
- The removal of the organ from the donor. Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a deceased or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Pregnancy and Maternity Care

Your Policy provides pregnancy and post-delivery care benefits for You and Your Family Members.

All comprehensive benefits described in this Policy are available for maternity services. Comprehensive Hospital benefits for routine nursery care of a newborn child are available so long as the child qualifies as an eligible dependent as defined in the section of this Policy titled "Who is Eligible for Coverage?"

The mother and her newborn child are entitled, under federal law, to inpatient Hospital coverage for a period of 48 hours following an uncomplicated vaginal delivery; and 96 hours following an uncomplicated delivery by cesarean section. We will not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization for prescribing a length of stay that does not exceed the above periods. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother. If a decision is made between a mother and doctor to discharge a mother or newborn child from inpatient care before the 48 or 96 hour time period, coverage for timely post-delivery care is available.

This Policy provides benefits for complications of pregnancy. Benefits are available for other pregnancy and maternity care as indicated above under "Pregnancy and Maternity Care."

Preventive and Primary Care Services

This Policy provides benefits for Covered Expenses incurred for:

- Office visits for primary care services.
- Virtual visits for primary care services.
- Office visits for specialty care services.
- Virtual visits for specialty care services.

For the purpose of this benefit, Virtual visits must be delivered through secure internet-based technologies using real-time audio and video connectivity between a patient and a health care provider.

You are entitled to benefits for Preventive Care Covered Services.

“Preventive Care” services generally describe health care services performed to catch the early warning signs of health problems. These services are performed when You have no symptoms of disease.

We periodically review the Primary and Preventive Care Covered Services based on recommendations from organizations such as:

- The American Academy of Pediatrics;
- The American College of Physicians;
- The U.S. Preventive Services Task Force; and
- The American Cancer Society.

Accordingly, the frequency and eligibility of Covered Services are subject to change. A list of Preventive Care Covered Services can be found in the Preventive Schedule on page 10 of this document. A complete listing of recommendations and guidelines can be found at https://www.healthcare.gov/preventive-care-benefits/.

We reserve the right to modify the Preventive Schedule document at any time after written notice of the change has been given to You.

Rehabilitative Therapy Services (Physical Therapy, Occupational Therapy and Speech Therapy)

This Policy provides benefits for Covered Expenses incurred for the following rehabilitative services:

- Therapeutic use of heat, cold, exercise, electricity or ultraviolet light; or
- Manipulation of the spine; or
- Massage to improve circulation, strengthen muscles, encourage return on range of motion, as part of treatment for an Illness or Injury; and
- Services for the necessary care and treatment of loss or impairment of speech.

Benefits are provided up to any maximum number of visits shown in the benefit schedule. For the purposes of this benefit, the term "visit" includes any outpatient visit to a duly licensed Physical, Occupational or Speech Therapist during which one or more Covered Services are provided. All supplies and additional fees charged in conjunction with these services will be included in the payment of benefits for the visit and will not be reimbursed in addition to the visit.

Spinal Manipulation Therapy

This Policy provides benefits for Covered Expenses incurred for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

Surgical Services

For any eligible condition, this Policy provides indicated benefits for Covered Expenses for:

- Inpatient services and supplies provided by the Hospital except private room Charges above the prevailing two-bed room rate of the facility.
- Outpatient services and supplies including those in connection with Emergency Services, outpatient surgery and outpatient surgery performed at a Free-Standing Outpatient Surgical Facility.

- Diagnostic/therapeutic lab and x-rays.
- Anesthesia and Inhalation therapy.
- Second Surgical Opinion.

Therapy Services

This Policy provides benefits for Covered Expenses incurred for the following forms of therapy:

- **Pulmonary and Cardiac Rehabilitation Therapy:** Includes pulmonary rehabilitation, and Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program within 30 days following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.
  - Note: Phase III and Phase IV cardiac rehabilitation are not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.
- **Chemotherapy**: The treatment of malignant disease by chemical or biological antineoplastic agents used to kill or slow the growth of cancerous cells. The cost of these drugs/biologics is covered, provided it meets all the following criteria:
  - Drugs/biologics are approved by the U.S. Food and Drug Administration (FDA) as antineoplastic agents.
  - The FDA- approved use is based on reliable evidence demonstrating positive effect on health outcomes and/or the use is supported by the established referenced Compendia identified in the Company's policies.
  - Drugs/biologics are eligible for coverage when they are injected or infused into the body by a professional provider.
- **Dialysis:** Covered Services included dialysis treatments in an outpatient dialysis Facility or doctor's office. Covered Services also include home dialysis.
- **Infusion Therapy:** The infusion of a drug, hydration, or nutrition into the body by a healthcare provider. Covered Services include all professional services, supplies, and equipment that are required to administer the therapy.
- **Radiation Therapy:** Benefits are provided for the treatment of disease by x-ray, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery, including the cost of radioactive materials supplied and billed by the provider.
- **Respiratory Therapy:** Includes the introduction of dry or moist gases into the lungs for treatment purposes. Coverage will also include services by a respiratory therapist.

Urgent Care

Urgent care services include Medically Necessary services by in-network providers and services provided at an urgent care center including facility costs and supplies. Care that is needed after a primary care provider's normal business hours may also considered to be urgent care.

Virtual Care Services (Telemedicine)

Virtual care services are provided by contracted vendors who are licensed to provide standard medical assessments, treatments, care and services to patients via the telephone, secure video, audio or instant messaging when a Professional provider is unavailable or inaccessible.

Exclusions and Limitations: What Is Not Covered by This Policy

Excluded Services

In addition to any other exclusions and limitations described in this Policy, there are no benefits provided for the following:

1. **Services obtained from a Non-Participating/Out-of-Network Provider**, except for treatment of an Emergency Medical Condition or for non-emergency care provided by an out-of-network provider at an in-network facility.
2. Any amounts in excess of maximum benefit limitations of Covered Expenses stated in this Policy.
3. Services not specifically listed as Covered Services in this Policy.
4. Services or supplies that are not Medically Necessary except for Preventive Services.
5. Services, items or supplies that are considered to be Experimental **Procedures or Investigational Procedures or Unproven Procedures**.
6. Services **received before the Effective Date of coverage**.
7. Services **received after coverage under this Policy ends**.
8. Services **for which You have no legal obligation to pay** or for which no charge would be made if You did not have a health plan or insurance coverage.
9. Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, **under any workers' compensation, employer's liability law or occupational disease law**, even if the Insured Person does not claim those benefits.
10. Conditions caused by: (a) an **act of war (declared or undeclared)**; (b) the **inadvertent release of nuclear energy** when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person **participating in the military service of any country**; (d) an Insured Person **participating in an insurrection, rebellion, or riot;** (e) services received as a direct result of an Insured Person's commission of, or attempt to commit a **felony** (whether or not charged) **or as a direct result of the Insured Person being engaged in an illegal occupation;** (f) an Insured Person being intoxicated, as defined by applicable state law in the state where the Illness occurred or under the influence of illegal narcotics or non-prescribed controlled substances unless administered or prescribed by Physician.
11. Any **services provided by a local, state or federal government agency**, except when payment under this Policy is expressly required by federal or state law.
12. Any services required by state or federal law to be supplied by a public school system or school district.
13. Any **services for which payment may be obtained from any local, state or federal government agency** (except Medicaid). Veterans Administration Hospitals and military treatment facilities will be considered for payment according to current legislation.
14. **If the Insured Person is eligible for Medicare** Part A, B, C or D, We will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount We would have paid if it were the sole insurance carrier.
15. **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician and listed as covered in this Policy.

16. Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Physician, from any of the following:
    a. Yourself or Your employer;
    b. A person who lives in the Insured Person's home, or that person’s employer;
    c. A person who is related to the Insured Person by blood, marriage or adoption, or that person’s employer; or
    d. A facility or health care professional that provides remuneration to You, directly or indirectly, or to an organization from which You receive, directly or indirectly, remuneration.
17. Services of a Hospital emergency room **for any condition that is not an Emergency Medical Condition** as defined in this Policy.
18. **Custodial Care, including but not limited to rest cures; infant, child or adult day care, including geriatric day care**.
19. **Private duty nursing** except when provided as part of the home health care services or Hospice Care Services benefit in this Policy.
20. Inpatient room and board charges in connection with a Hospital stay primarily for environmental change or Physical Therapy.
21. Services received during **an inpatient stay when the stay is primarily related to** behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of a Mental Health Disorder.
22. **Complementary and alternative medicine services, including but not limited to**: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; meditation; visualization; acupuncture; acupressure; acupuncture point injection therapy; reflexology; rolfing; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy; hypnosis; energy-balancing; breathing exercises; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf; and any other alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. Services specifically listed as covered under “Rehabilitative Therapy” and “Habilitative Therapy” are not subject to this exclusion.
23. Any services or supplies **provided by or at a place for the aged, a nursing home, or any facility** a significant portion of the activities of which include rest, recreation, leisure, or any other services that are not Covered Services.
24. **Assistance in activities of daily living**, including but not limited to: bathing, eating, dressing, or other Custodial Care, self-care activities or homemaker services, and services primarily for rest, domiciliary or convalescent care.
25. **Services performed by unlicensed practitioners** or services which do not require licensure to perform, for example: meditation, breathing exercises, and guided visualization.
26. Inpatient room and board **charges in connection with a Hospital stay primarily for diagnostic tests** which could have been performed safely on an outpatient basis.
27. **Dental services**, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
28. **Orthodontic services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
29. **Dental implants**: dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
30. Any services covered under **both this medical plan and an accompanying exchange-certified pediatric dental plan** and reimbursed under the dental plan will not be reimbursed under this plan.
31. **Hearing aids** including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as specifically stated in this Policy, limited to the least expensive professionally adequate device. For the purposes of this exclusion, a hearing aid is any device that amplifies sound.

32. **Routine hearing tests** except as provided under Preventive Care.
33. For **assisted fertilization techniques** such as, but not limited to, in vitro fertilization; embryo transplant; ovum retrieval, including gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and any services required in connection with these procedures.
34. **Genetic screening**: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
35. **Gene Therapy** including, but not limited to, the cost of the Gene Therapy product, and any medical, surgical, professional and facility services directly related to the administration of the Gene Therapy product.
36. **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision Care.
37. **Eye surgery solely for the purpose of correcting refractive defects of the eye**, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
38. **Cosmetic surgery**, or similar procedures to improve or alter appearance. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a newborn child, or for Medically Necessary Reconstructive Surgery performed on one breast or both breasts following a mastectomy, as determined by the treating physician, to reestablish symmetry between the two breasts or alleviate functional impairment caused by the mastectomy.
39. **Aids or devices that assist with nonverbal communication,** including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, personal digital assistants (PDAs), braille typewriters, visual alert systems for the deaf and memory books except as specifically stated in this Policy.
40. **Non-medical counseling or ancillary services**, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities and developmental delays, except as otherwise stated in this Policy.
41. **Services and procedures for redundant skin surgery** including abdominoplasty/panniculectomy, removal of skin tags, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; varicose veins; rhinoplasty; blepharoplasty, and; orthognathic surgeries regardless of clinical indications.
42. Procedures, surgery or treatments **to change characteristics of the body** to those of the opposite sex unless coverage for such services are deemed to be required by law.
43. Any treatment, Prescription Drug, service or supply **to treat sexual dysfunction**, enhance sexual performance or increase sexual desire.
44. **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
45. Fees associated with the **collection or donation of blood or blood products**, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
46. Blood or blood product administration for the purpose of general improvement in physical condition.
47. **Orthopedic shoes** (except when joined to Braces), shoe inserts, foot Orthotic Devices. This exclusion shall not apply to coverage for orthotics or orthoses prescribed by a health care professional to treat insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes.
48. **External and internal power enhancements** or power controls for Prosthetic limbs and terminal

devices.
49. **Myoelectric Prostheses** peripheral nerve stimulators.
50. **Electronic Prosthetic limbs or appliances** unless Medically Necessary, when a less-costly alternative is not sufficient.
51. Prefabricated foot Orthoses. This exclusion shall not apply to coverage for orthotics or orthoses prescribed by a health care professional to treat insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes.
52. **Cranial banding/cranial Orthoses/other similar devices**, except when used postoperatively for synostosis plagiocephaly.
53. **Orthosis shoes**, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers. This exclusion shall not apply to coverage for orthotics or orthoses prescribed by a health care professional to treat insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes.
54. Orthoses primarily used for cosmetic rather than functional reasons.
55. **Non-foot Orthoses**, except **only** the following non-foot Orthoses are covered when Medically Necessary:
    a. Rigid and semi-rigid custom fabricated Orthoses;
    b. Semi-rigid prefabricated and flexible Orthoses; and
    c. Rigid prefabricated Orthoses, including preparation, fitting and basic additions, such as bars and joints.
56. Services primarily for **weight reduction or for the medical or surgical treatment of obesity including morbid obesity**, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Insured Person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction, including drugs whether being used off-label or FDA approved to treat obesity.
57. **Routine physical exams or tests** that do not directly treat an actual Illness, Injury or condition. This includes reports, evaluations, or hospitalization not required for health reasons; physical exams
58. required for or by an employer or for school, or sports physicals, or for insurance or government authority, and court ordered, forensic, or custodial evaluations, except as otherwise specifically stated in this Policy. This exclusion does not apply to Physical Exams which are indicated Preventive Services.
59. Therapy or treatment **intended primarily to improve or maintain general physical condition** or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
60. **Educational services** except for Diabetic Self-Management Training Programs, treatment for Autism, or as specifically provided or arranged by Us.
61. Nutritional counseling or food supplements, except as stated in this Policy.
62. **Exercise equipment, comfort items and other medical supplies and equipment** not specifically listed as Covered Services in the “Comprehensive Benefits: What the Policy Pays For” section of this Policy. Excluded medical equipment includes, but is not limited to: air purifiers, air conditioners, humidifiers; treadmills; spas; elevators; supplies for comfort, hygiene or beautification; wigs, disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this Policy.
63. **Certain Consumable Medical Supplies,** including any item that is for comfort or convenience and
    a. Is not primarily medical in nature. Such items not covered include, but are not limited to: ear plugs; ice packs; silverware/utensils; feeding chairs; and toilet seats;

b. Has features which are medical in nature but which are not required by the patient's condition; and
c. Is one for which the FDA does not require a prescription from an eligible provider in order to dispense and is generally available without a prescription.

Some examples of not covered consumable medical supplies are: incontinence pads; lamb's wool pads; face masks (surgical); disposable gloves, sheets and bags, bandages intended for single use, antiseptics, skin preparations, infant formulas or other non-prescription medical foods or enteric formulas.

64. **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the benefit schedule and under "Rehabilitative Therapy Services (Physical Therapy, Occupational Therapy and Speech Therapy)" in the section of this Policy titled "Comprehensive Benefits: What the Policy Pays For."
65. **Foreign Country Provider** charges except as specifically stated under "Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits: What the Policy Pays For."
66. **Routine foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, a systemic condition, Injury or symptoms involving the feet except as otherwise stated in this Policy.
67. **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
68. Charges for the services of a standby Physician.
69. Charges for animal to human organ transplants.
70. Charges for non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).

Prescription Drug Benefits

Pharmacy Payments

For definitions associated with Prescription Drug benefits, refer to the “Definitions” section of this Policy. Prescription Drug benefits are subject to the provisions within this section, and all other Policy provisions.

Our Formulary is available upon request by calling the member relations number on Your ID card or https://www.jeffersonhealthplans.com/individuals-families/
Your responsibility for covered Prescription Drugs and Related Supplies will always be the lowest of:

- The Copayment or Coinsurance for the Prescription Drug; or
- Our discounted rate for the Prescription Drug; or
- The Pharmacy’s Usual and Customary (U&C) charge for the Prescription Drug.

Usual & Customary (U&C) means the lowest price a Participating Pharmacy would charge to a particular customer if such customer were paying cash for filling an identical prescription on that particular day at that particular location, as submitted by Participating Pharmacy. This price must include any applicable dispensing fee and/or level of effort and must include any applicable discounts offered to attract customers.

Coupons, Incentives and Other Communications

If any reimbursements, discounts or payments are made on Your behalf toward any portion of Your Copayment, Prescription Drug Deductible, Deductible, and/or Coinsurance, from a Pharmacy, pharmaceutical manufacturer or other third party which is not a public charity subject to IRS 501c(3) regulations for a Prescription Drug or Related Supply covered under this Policy, Your Prescription Drug benefits may not apply.

If such reimbursements, discounts or payments are received without Our consent, We may deny payment or reduce the payment of the claims in proportion to the amount of the Copayment, Prescription Drug Deductible, Deductible, and/or Coinsurance amounts received, regardless of whether the Pharmacy, pharmaceutical manufacturer or other third party has indicated that You are responsible for any amounts that Your plan does not cover. We also have the right to require You to provide proof sufficient to Us that You have made Your required Cost Share payment(s) prior to the payment of any benefits by Your plan.

For example, if You use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a Prescription Drug, We may reduce the benefits provided under Your plan in proportion to the amount of the Copayment, Prescription Drug Deductible, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward Your plans Prescription Drug Deductible, Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Prescription Drug Deductible, Deductible, and/or Coinsurance You are required to pay.

Our Specialty Pharmacy

Our formulary includes medications that are called specialty medications. Specialty medications are prescription drugs that require special handling, administration, monitoring self-administered or have limited distribution. These medications treat complex chronic conditions and are only available from a participating specialty pharmacy.

Our ACA Exchange works with a network of specialty pharmacies to coordinate the delivery of specialty medications for Our members who have to meet Our quality terms.

A prescription for these medications may need to be prior authorized. You may have a copayment for Your medicine. To see Our ACA Exchange formulary and a complete list of specialty medications, call the number on the back of Your ID card or visit Our website at https://www.jeffersonhealthplans.com/individuals-families/

A preferred specialty pharmacy can mail Your medications directly to You. You will not be charged for the delivery, but applicable copays will apply. The specialty pharmacy will contact You before sending Your medicine. The pharmacy can also answer any questions You have about the process. We have a preferred Specialty Pharmacy, Jefferson Specialty Pharmacy, to help with all of Your specialty medication needs. For the list of network specialty pharmacies, call the number on the back of Your ID card or visit Our website at https://www.jeffersonhealthplans.com/individuals-families/

Prior Authorizations for Specialty Medications

If You have been prescribed a specialty medication, please talk to Your doctor about submitting a Prior Authorization request on Your behalf. Please discuss with Your doctor about choosing a specialty pharmacy to coordinate the delivery of Your medication. If a specialty pharmacy is not selected by You or Your doctor within 24 hours from receipt of the Prior Authorization request, We will select a participating pharmacy on Your behalf. If You have questions, call the number on the back of Your ID card.

Prescription Drug List or Formulary

Our formulary is a list of the preferred drugs that are covered by Your health plan.

We have a comprehensive formulary, which is a complete list of covered, commonly prescribed prescription drugs. These drugs are selected by a team of health care providers, including doctors and pharmacists, based on their medical advantage, safety, ease of use and cost. New drugs and treatments are reviewed regularly. Our Exchanges will make changes to the formulary as needed.

Our formulary is reviewed on a regular basis and there may be changes to it throughout the year. We may add or remove drugs from the formulary, make quantity limits or other restrictions. We may also change a drug's cost-sharing tier.

Brand name and generic drugs

Our formulary contains two kinds of drugs: brand name drugs and generic drugs. We usually do not include a brand name when the same medicine comes as a generic. This may affect which medications You get when using Your prescription benefit. When You search for a brand name drug, the formulary will show You the generic equivalent, if available. You can also use the formulary on the website to find out about drug side effects, interactions, risks and proper usage. To view this information, click on the icon for "Details" in Your search results. Throughout the year, We may elect to make changes to Our formularies. Updates will be noted on the website.

Covered Expenses

If an Insured Person, while covered under this Policy, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, We will provide coverage for those expenses as shown in the benefit schedule as long as they are in the formulary. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a Prescription issued to You or Your Family Members by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When You or Your Family Members are issued a Prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that Prescription cannot reasonably be filled by a Participating Pharmacy, the Prescription will be covered by Us as if filled by a Participating Pharmacy.

Coverage of Non-Formulary Drugs

If we agree to cover a generic drug not on the Prescription Drug List for Formulary, you will need to pay the cost-sharing amount that applies to drugs in the Generic Drug tier. If we agree to cover a brand drug not on the Prescription Drug List for Formulary, you will need to pay the cost-sharing amount that applies to drugs in the Non-Preferred Drug tier. A deductible may apply. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.

Prior Authorization/Formulary Exceptions

There may be occasions when Your doctor would like You to have a drug that is not listed in Our formulary or may have specific clinical criteria that requires a prior authorization review. To be sure that certain medications are used appropriately, Prior Authorization (plan approval) may be required before prescriptions for these drugs can be filled.

Prior Authorization may be required for the following drugs and reasons:

- Non-formulary medications or benefit exceptions required by medical necessity
- All brand name medications when there is an A-rated generic version available
- Medications and/or treatments if they are under clinical investigation
- Medications prescribed for non-FDA approved uses
- Prescriptions that exceed set plan limits (days' supply, quantity, cost)
- New-to-market products
- Medications that have treatment guidelines developed by Our Pharmacy & Therapeutics Committee

In these instances, the non-formulary medication may be requested through a Prior Authorization/Formulary Exception.

How do I request an exception or other coverage decision?

You, Your prescriber, or Your representative can request a coverage decision. For exception requests, We also need a statement from Your prescriber supporting Your request. Generally, We must make Our decision within 48 hours of getting Your prescriber's supporting statement. You can request an expedited (fast) decision if You or Your prescriber believe that Your health could be seriously harmed by waiting up to 48 hours for a decision. If Your request to expedite is granted, We must give You a decision no later than 24 hours after We get a supporting statement from Your prescriber. To request an initial coverage decision by phone, call the number on the back of Your ID card. To request a coverage decision in writing, please include Your name, date of birth, member ID number, the drug name (and strength and directions), the amount of drug You need and Your doctor's name and phone number. You can use the Request form on Our website at https://www.jeffersonhealthplans.com/individuals-families/

Step Therapy

Certain drugs in Our formularies may have Step Therapy requirements. Step therapy helps assure that You receive the most appropriate and cost-effective drug to treat Your condition.

Here's how it works:

When Step Therapy applies, We require You to try certain drugs to treat Your medical condition first before We will cover another drug for that condition.

For example, if Drug A and Drug B both treat Your medical condition, We may not cover Drug B unless You try Drug A first. If Drug A does not work for You, We will then cover Drug B.

Drugs subject to Step Therapy are marked with an "ST" code in Our print and online formularies.

What Is Covered:

- Outpatient drugs and medications that federal and/or applicable state law restrict to sale by Prescription only, except for certain insulin which do not require a Prescription.
- Pharmaceuticals to aid smoking cessation in accordance with "A" or "B" recommendations of the U.S. Preventive Services Task Force.
- Insulin; syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; oral hypoglycemic agents; Glucagon Emergency Kits and alcohol swabs.
- Orally administered anti-cancer medications prescribed in connection with cancer chemotherapy treatments.
- All non-infused compound Prescription Drugs that contain at least one FDA approved Prescription ingredient compounded from an FDA-approved finished pharmaceutical product and are otherwise covered under the Pharmacy benefits, excluding any bulk powders included in the compound.
- Contraceptive drugs and devices approved by the FDA as listed on the formulary.
- Specialty Medications.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, when available for administration at a Participating Pharmacy.

Conditions of Service

The drug or medication must meet all of the following conditions:

- Prescribed by a Physician and dispensed within one year of being prescribed, subject to federal or state laws.
- Approved for use by the Food and Drug Administration.
- For the direct care and treatment of the Insured Person's Illness, Injury or condition; however dietary supplements, health aids or drugs for cosmetic purposes are not covered, even if prescribed by a Physician for the care and treatment of an Insured Person's Illness.
- Purchased from a licensed retail Pharmacy or ordered by mail through CVS/Caremark Pharmacy.
- The Prescription must not exceed the days' supply indicated in the "Limitations" section below.
- Infusion and Injectable Medications and Specialty Medications may require Prior Authorization or Step Therapy.

We will not transfer your prescription from an in-network pharmacy to another pharmacy unless requested by you.

Exclusions

The following are not covered under this Policy; no payment will be made for the following expenses:

1. Drugs not approved by the Food and Drug Administration;
2. Any drugs that are not on the formulary and not otherwise approved for coverage through the non-formulary exception process;
3. Drugs, devices and/or supplies available over the counter that do not require a Prescription by federal or state law except as otherwise stated in this Policy, or specifically designated as No Cost Preventive Care and required by the Patient Protection and Affordable Care Act (PPACA);
4. Drugs that do not require a federal legend (a federal designation for drugs requiring supervision of a Physician), other than insulin;
5. Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
6. A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
7. Injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs are covered under the medical benefits of this Policy and require Prior Authorization. The following are examples of Physician supervised drugs: chemotherapy injectables and endocrine and metabolic agents;
8. Infused Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions are covered under the medical benefits of this Policy;
9. Any drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido and/or sexual desire;
10. Any drugs used for weight loss, weight management, metabolic syndrome, and antiobesity agents;
11. Any drugs that are Experimental or Investigational or Unproven as described in this Policy; except as specifically stated in the sections of this Policy titled "Clinical Trials," and any benefit language concerning "Off Label Drugs";
12. Food and Drug Administration FDA-approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language biomedical journals;
13. Implantable contraceptive products inserted by the Physician are covered under the Policy's medical benefits;

14. Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies, except for those pertaining to Diabetic Supplies and Equipment;
15. Prescription vitamins other than prenatal vitamins; dietary supplements, herbal supplements and fluoride other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);
16. Drugs used for cosmetic purposes that have no medically acceptable use, such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
17. Medications used for travel prophylaxis, except anti-malarial drugs;
18. Drugs obtained outside the United States;
19. Any fill or refill of Prescription Drugs and Related Supplies to replace those lost, stolen, spilled, spoiled or damaged before the next refill date;
20. Drugs used to enhance athletic performance;
21. Drugs which are to be taken by or administered to You while a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar Institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
22. Any Drugs, medications, or other substances dispensed or administered in any outpatient setting. This includes, but is not limited to, items dispensed by a Physician;
23. Drug convenience kits;
24. Prescriptions more than one year from the original date of issue;
25. Any costs related to the mailing, sending or delivery of Prescription Drugs;
26. Any intentional misuse of this benefit, including Prescription Drugs and Related Supplies purchased for consumption by someone other than You.

Limitations

Each Prescription Order or refill, unless limited by the drug manufacturer's packaging, shall be limited as follows:

- Up to a 30-day supply, at a Participating Retail Pharmacy for drug tiers 1 through 4 and up to a 30-day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers please refer to the benefit schedule).
- Up to a 90-day supply, at a 90 Day Retail Pharmacy for drug tiers 1 through 4 and up to a 30-day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging. To locate a 90 Day Retail Pharmacy You can call the Member Relations number on Your ID card or go to https://www.jeffersonhealthplans.com/individuals-families/ (for detailed information about drug tiers please refer to the benefit schedule).
- Up to a 90-day supply at CVS/Caremark Mail Order Pharmacy, or participating Retail Pharmacies for drug tiers 1 through 4 and up to a 30-day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers please refer to the benefit schedule).
- Quantity limits (QL) may apply to medications on the formulary and are noted in the formulary; quantity limits are approved by the P&T Committee and are based on best practice clinical recommendations, the Food and Drug Administration (FDA) and the drug manufacturer.

Medication Synchronization

We will allow and apply a prorated daily Cost Share rate to Prescription Drugs that are dispensed by a Participating Pharmacy for a partial supply if the prescribing Physician or the pharmacist determines the fill or refill to be in Your best interest and he/she requests or agrees to a partial supply for the purpose of synchronizing his/her medications, provided that such a proration for any Prescription Drug does not occur more frequently than three times a year.

Authorization, Exception and Appeal Process for Prescription Drugs and Related Supplies

Authorization from Us is required for certain Prescription Drugs and Related Supplies, meaning that Your Physician must obtain Authorization from Us before the Prescription Drug or Related Supply will be covered.

Prior Authorization
When Your Physician prescribes certain Prescription Drugs or Related Supplies, including high cost and Specialty Medications, We require Your Physician to obtain Authorization before the Prescription or supply can be filled. To obtain Prior Authorization, Your Physician must follow the Prescription Drug and Related Supply Authorization and Exception Request Process as described below.

Step Therapy
Step Therapy is a type of Prior Authorization. We may require an Insured Person to follow certain steps before covering some Prescription Drugs and Related Supplies, including without limitation, some higher- cost and Specialty Medications. If a Prescription Drug or Related Supply is subject to a Step Therapy requirement, then You must try one or more similar Prescription Drugs and Related Supplies before the Policy will cover the requested Prescription Drug or Related Supply. The Prescription Drugs and Related Supplies that require Step Therapy can be identified on the Formulary at https://www.jeffersonhealthplans.com/individuals-families/ to obtain Step Therapy Authorization, Your Physician must follow the Prescription Drug and Related Supply Authorization and Exception Request Process as described below.

Step Therapy or history of drug failure, will not be required for Prescription Drugs related to the treatment of stage four, advanced metastatic cancer, if both of the following apply:

- The drug is approved by the United States Food and Drug Administration for this indication; and
- The prescription of the drug is consistent with the best clinical practices for the treatment of stage four, advanced metastatic cancer or a severe adverse health condition experienced as a result of stage four, advanced metastatic cancer, and is supported by peer-reviewed medical literature.

Exceptions for Prescription Drugs and Related Supplies Not on the Formulary
If Your Physician prescribes a Prescription Drug or Related Supply that is not on Our Formulary, he or she can request that We make an exception and agree to cover that drug or supply for Your condition. To obtain an exception for a Prescription Drug or Related Supply, Your Physician must follow the Prescription Drug and Related Supply Authorization and Exception Request Process as described below.

Prescription Drug and Related Supply Authorization and Exception Request Process
To obtain an exception, Your Physician may call Us, or complete the appropriate form and fax it to Us to request an exception. Your Physician can certify in writing that You have previously used a Prescription Drug or Related Supply that is on Our Formulary or in a Step Therapy Protocol, and the Prescription Drug or Related Supply has been detrimental to Your health or has been ineffective in treating Your condition and, in the opinion of Your Physician, is likely to again be detrimental to Your health or ineffective in treating the condition. The exception request will be reviewed and completed by Us within 48 hours of receipt.

Expedited Review of a Prior Authorization, Step Therapy or Prescription Drug Exception Request
An expedited review may be requested by Your Physician when You are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function or when You are undergoing a current course of treatment using a Prescription Drug or Related Supply not on Our Formulary. The expedited review will be reviewed and completed by Us within 24 hours of receipt.

If the request is approved, Your Physician will receive confirmation. The Authorization/Exception will be processed in Our pharmacy claim system to allow You to have coverage for those Prescription Drugs or

Related Supplies. The length of the Authorization will be granted until You no longer use the Prescription Drug or Related Supply for which the Authorization or Exception was approved. When Your Physician advises You that coverage for the Prescription Drugs or Related Supplies has been approved, You should contact the Pharmacy to fill the Prescription(s).

If the request is denied, You and Your Physician will be notified that coverage for the Prescription Drugs or Related Supplies was not authorized.

Appeal of a Prior Authorization, Step Therapy or Prescription Drug Exception Denial
If You, a person acting on Your behalf or the prescribing Physician or other prescriber disagree with a coverage decision, You, a person acting on Your behalf, or the prescribing Physician or other prescriber may appeal that decision in accordance with the provisions of this Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered. Please see the section of this Policy entitled "When You Have a Complaint or an Appeal" which describes the process for an internal Plan appeal and external independent review.

If You have questions about specific Formulary exceptions, Prior Authorization or a Step Therapy request, call Member Relations at the toll-free number on the back of Your ID card.

Coverage of New Drugs

All new FDA-approved Prescription Drugs or Related Supplies (or new FDA-approved indications) are designated as non-Formulary Prescription Drugs or Related Supplies until the P&T Committee (P&T) makes a placement decision on the formulary, which decision shall be based in part on the P&T Committee's clinical review of the drug. The P&T Committee makes a reasonable effort to review all new FDA approved Prescription Drugs or Related Supplies (or new FDA-approved indications) within 180 days of its release onto the market, or a clinical justification must be documented if this timeframe is not met.

Reimbursement/Filing a Claim

When an Insured Person purchases Prescription Drugs or Related Supplies through a retail Participating Pharmacy they pay any applicable Copayment, Coinsurance or Deductible shown in the benefit schedule at the time of purchase. The Insured Person does not need to file a claim form.

Reimbursement for Medication paid outside of the insurance claim

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. Please check first with Member Relations to see if there is a network pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy: If you pay for a prescription at an out-of-network pharmacy in the United States, you can submit your detailed receipt and explanation to the plan for possible reimbursement. Any reimbursement will be limited to that for a 30-day supply. If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost.

Age of Reimbursement Claim

Some prescriptions require review for medical necessity before We will pay for them. This is called Prior

Authorization (PA). Others do not. If the prescription requires no review, in other words, it would have been paid without any intervention from Us, then the prescription may be reviewed for reimbursement. Prescriptions older than 1 year will not be reviewed regardless if it requires a PA or not.

Age of Prior Authorization

Prior Authorization of medications requires clinical review at the time of the request. Due to the nature of the medical review, older requests can result in inadequate and incomplete records. Therefore, any reimbursement request that requires a Prior Authorization that was not approved previously and is older than 30 days from the time the prescription was filled, will not be reviewed.

Prescription Drugs Covered under the Medical Benefits

When Medical Prescription Drugs not on Our Formulary are administered in a health care setting by a Physician or Other Health Care Professional, and are billed with the office or facility charges, they will be covered under the medical benefits of this Policy. These medications may still be subject to Prior Authorization or Step Therapy requirements.

Pediatric Vision Care

Please be aware that the pediatric vision network is different from the network of Your medical benefits.

Covered pediatric vision benefits are subject to any applicable cost sharing shown in the benefit schedule, where applicable.

Benefits will apply until the end of the month in which the Insured Person turns age 19.

Note: Routine vision screening performed by a PCP or pediatrician is covered under the preventive services benefit

Covered Services

Covered Services are limited as detailed below. Covered Services for an Insured Person include:

- Examinations – Vision and eye health evaluations by an optometrist or an ophthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.
- Eyeglass lenses include all prescriptions including prism, choice of polycarbonate, glass or plastic standard single vision, lined bifocal, lined trifocal, lenticular and standard progressive lenses, including these additional lens add-ons:
  - Oversize lenses
  - All solid and gradient tints
  - Scratch-coating
  - Ultra-violet (UV) coating
  - Minimum 20% savings* on all additional lens enhancements You choose for Your lenses, including but not limited to: anti-reflective coatings; photochromic (glass or plastic) for polarized; hi-index and lens styles such as blended segment, intermediate, and Premium progressive lenses.

    *Provider participation is 100% voluntary. Please check with Your eye care professional for any offered discounts.
- Frames – Only frames in the pediatric Davis frame collection are covered at 100%; there is a one-year warranty for standard frames. There is no coverage for non-Davis frame collections.
- Coverage is limited to three pairs of pediatric collection frames and lenses every calendar year. Coverage for the second and third pair of glasses is dependent on a change in the Insured Person's refractive state or to replace broken, damaged or lost glasses.
- Lenses and frames covered if:
- Diopter Change is greater than or equal to .50 Diopters or
- Axis Change is greater than or equal to 15 Degrees or
- Prism Change is greater than or equal to .50 Diopters or
- Improve visual acuity by at least one line on the standard eye chart.
- Therapeutic contact lenses are covered for a one-year supply, regardless of the contact lens type, including professional services, in lieu of frame and lenses. Coverage for therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses

- and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakia; as determined and documented by Your vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction are not covered.

Exclusions

- Services not provided by an In-Network vision Provider.
- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Any Injury or Illness when paid or payable by Workers' Compensation or similar law, or which is work related.
- Charges in excess of the U&C charge for the service or material.
- Charges incurred after the Policy ends or Your coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "Covered Services" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lenses, treatments, add-ons, or lens coatings not otherwise listed in "Covered Services" within this section, above.
- Two pairs of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- For or in connection with Experimental Procedures or treatment methods not approved by the American Medical Association or the appropriate vision specialty society.
- Claims submitted and received in excess of twelve (12) months from the original date of service.
- Services provided out-of-network without Our prior approval are not covered.
- Elective contact lenses.
- Low vision services.

Vision Providers

To find a vision Provider, get a claim form, or for more information on the pediatric vision benefits, visit https://www.jeffersonhealthplans.com/individuals-families/ or call Member Relations at the number on the back of Your ID card.

General Provisions

Third Party Liability
We may have a right to take legal action, to the extent of benefits advanced, upon any recovery that You receive from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. Any recovery will be in the amount of benefits paid by Us under this Policy for the treatment of the Illness, disease, Injury or condition for which the third party is liable. We shall pursue such legal action to the extent permitted by law. A court of law will determine Our recovery including the sources from which such recovery may be made. You shall not take any action that would prejudice Our right to recovery in the case of third-party liability.

Alternate Cost Containment Provision
We may, in certain situations, approve services under an alternate treatment plan. An alternate treatment plan may include services or supplies otherwise limited or excluded by the Policy. The alternate treatment plan must be mutually agreed to by Us, the Insured Person, and the Physician, Provider, or other healthcare practitioner. Our offering an alternate treatment plan in a particular case in no way commits Us to do so in another case, nor does it prevent Us from strictly applying the express benefits, limitations, and exclusions of the Policy at any other time or for the Insured Person.

Coordination of Benefits
This section describes what this Policy will pay for Covered Expenses that are also covered under one or more other plans. You should file all claims with each plan.

Definitions
For the purposes of this section, the following terms have the meanings set forth below:

Plan
Any of the following that provides benefits in the form of payment or services for:
- An insurance plan issued to an individual/non-group or a group; or a self-insured group health plan providing benefits in the form of reimbursement or services for medical care or treatment/items.
- Governmental benefits as permitted by law, except for Medicaid, Medicare and Medicare supplement policies.
- Medical benefits coverage under any form of group or individual automobile insurance.
- Each plan or part of a plan which has the right to coordinate benefits will be considered a separate plan.

Primary Plan
The plan that pays first as determined by the Order of Benefit Determination Rules below.

Secondary Plan
The plan that pays after the Primary Plan as determined by the Order of Benefit Determination Rules below. The benefits under the Secondary Plan are reduced based on the benefits under the Primary Plan.

Allowable Expense
The portion of a Covered Expense used in determining the benefits this plan pays when it is the Secondary Plan. The Allowable Expense is the lesser of:
- The charge used by the Primary Plan in determining the benefits it pays;
- The charge that would be used by this plan in determining the benefits it would pay if it were the Primary Plan, and
- The amount of the Covered Expense.

If the benefits for a Covered Expense under Your Primary Plan are reduced because You did not comply with the Primary Plan's requirements (for example, getting pre-certification of Hospital admission or a second surgical opinion), the amount of the Allowable Expense is reduced by the amount of the reduction.

Claim Determination Period

Claim determination period is a Calendar Year but does not include any part of a year during which You are not covered under this plan or any date before this section or any similar provision takes effect.

Order of Benefit Determination Rules

A plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one that applies:

- The plan that covers You as an enrollee or an employee shall be the Primary Plan and the plan that covers You as a dependent shall be the Secondary Plan;
- If You are a dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the plan which covers the parent whose birthday falls first in the Calendar Year as an enrollee or employee;
- If You are the dependent of divorced or separated parents, benefits for the dependent shall be determined in the following order:
    - First, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
    - Then, the plan of the parent with custody of the child;
    - Then, the plan of the spouse of the parent with custody of the child;
    - Then, the plan of the parent not having custody of the child, and
    - Finally, the plan of the spouse of the parent not having custody of the child.
- The plan that covers You as an active employee (or as that employee's dependent) shall be the Primary Plan and the plan that covers You as a laid-off or retired employee (or as that employee's dependent) shall be the Secondary Plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The plan that covers You under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the plan that covers You as an active employee or retiree (or as that employee's dependent) shall be the Primary Plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the plans that covers You is issued out of the state whose laws govern this plan and determines the order of benefits based upon the gender of a parent, and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the plan that has covered You for the longer period of time shall be primary.

Effect on the Benefits Payable

- If this plan is the Primary Plan, the amount this plan pays for Covered Expenses will be determined without regard for the benefits payable under any other plan.
- If this plan is the Secondary Plan, the amount this plan pays for Covered Expenses is the Allowable Expense less the amount paid by the Primary Plan during a Claim Determination Period.

If while covered under this plan, You are also covered by another one of Our individual or group plans, You will be entitled to the benefits of only one plan. You may choose this plan or the plan under which You will be covered. We will then refund any Premium received under the other plan covering the time period both policies were in effect. However, any claim payments made by Us under the plan You elected to cancel will be deducted from any such refund of Premium.

Recovery of Excess Benefits
If this plan is the Secondary Plan and We pay for Covered Expenses that should have been paid by the Primary Plan, or if We pay any amount in excess of what it is obligated to pay, We will have the right to recover the actual overpayment made. We will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided, or such payments made by any insurance company, healthcare plan or other organization. If We request, You must execute and deliver to Us such instruments and documents as We determine are necessary to secure the right of recovery.

Right to Receive and Release Information
We, without consent or notice to You, may obtain information from and release information to any other plan with respect to You to coordinate Your benefits pursuant to this section. You must provide Us with any information We request to coordinate Your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, You will be advised that the "other coverage" information, (including an explanation of benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 55 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibles
If an Insured Person is eligible for Medicare, We will calculate the claim payment for Covered Services according to the benefit levels of this Policy based on the allowed amount defined below and pay this amount minus any amount paid by Medicare. We will estimate the amount Medicare would have paid and reduce benefits by this amount for any Insured Person who is eligible to enroll in Medicare but is not enrolled. In no event will the amount paid exceed the amount that We would have paid if it were the sole insurance carrier.

Under this scenario, the allowed amount will be the lesser of:
- The amount Medicare allowed; or
- Our Negotiated Rate for a Participating Provider; or
- Our Allowed Expense for a Non-Participating Provider.

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "You", "Your" or "Insured Person" also refers to a representative or Provider designated by You to act on Your behalf, unless otherwise noted.
We want You to be completely satisfied with the care and services You receive. That is why We have established a process for addressing Your concerns and solving Your problems.

Start with Member Relations

We are here to listen and help. If You have a concern regarding a person, a service, the quality of care, an initial eligibility denial, contractual benefits, or a rescission of coverage, You can call Our toll-free number and explain Your concern to one of Our Member Relations representatives. Please call Us at the Member Relations toll-free number on Your ID card, explanation of benefits or claim form.

We will do Our best to resolve the matter on Your initial contact. If We need more time to review or investigate Your concern, We will get back to You as soon as possible, but in any case, within 30 days.

If You are not satisfied with the results of a coverage decision, You can start the appeals procedure.

Appeals Procedure

To initiate an appeal for most claims, You must submit a request for an appeal within 180 days of receipt of a denial notice. If You appeal a reduction or termination in coverage for an ongoing course of treatment that We previously approved, You will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Jefferson Health Plans
Member Appeals Unit
1101 Market Street, Suite 3000
Philadelphia, PA 19707

You should state the reason why You feel Your appeal should be approved and include any information supporting Your appeal. If You are unable or choose not to write, You may ask to register Your appeal by telephone. Call Us at the toll-free number on Your ID card, explanation of benefits or claim form.

"If the appeal involves a decision based on issues of medical necessity, clinical appropriateness, the type of health care setting, the level of care, the effectiveness of the service, or Experimental treatment, a medical review will be conducted by a Physician reviewer in the same or similar specialty as the care under consideration, as determined by Our Physician reviewer. This is an Internal Appeal Review.

For all other plan related issues (i.e. a Grievance), a review will be conducted by someone who was a) not involved in any previous decision related to Your appeal, and b) not a subordinate of previous decision makers.

Provide all relevant documentation with Your appeal request.

We will acknowledge in writing that We have received the request within five working days after the date We receive Your request. For required pre-service and concurrent care coverage determinations, Our review will be completed within 30 calendar days. For post-service claims, Our review will be completed within 30 calendar days. If more time or information is needed to make the determination, We will notify the Insured Person in writing to request an extension of up to 15 calendar days and to specify any additional information needed by Us to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Us in connection with the appeal, We will provide this information to the Insured Person as soon as possible and sufficiently in advance of the decision, so that the Insured Person will have an opportunity to respond. Also, if any new or additional rationale is considered by Us, We will provide the rationale to the Insured Person as soon as possible and sufficiently in advance of the decision so that the Insured Person will have an opportunity to respond.

The Insured Person will be notified in writing of the decision within five working days after the decision is made, and within the review time frames above if We do not approve the requested coverage.

The Insured Person may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize the Insured Person's life, health or ability to regain maximum function or in the opinion of his or her Physician would cause severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient Hospital stay. If the Insured Person requests that the appeal be expedited based on (a) above, the Insured Person may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to the Insured Person’s medical condition.

A Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, We will respond orally with a decision within 48 hours, followed up in writing.

If the Insured Person is not satisfied with Our decision regarding eligibility of an expedited external review, the Insured Person may file a complaint with the Insurance Commissioner’s office. The Insurance Commissioner may make a different determination regarding the Insured Person’s eligibility for an expedited external review. The Insurance Commissioner’s office may be contacted at the following address and telephone number:

Pennsylvania Insurance Department Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120

Toll-Free Number: 877-881-6388
Fax: 717-787-8585

Independent Review Procedure

If You are not fully satisfied with the appeal review decision regarding the medical necessity, clinical appropriateness, health care setting, level of care, or the effectiveness of a service, You may request that Your appeal be referred to an Independent Review Organization. You also have the right to a review of whether We complied with the surprise billing and cost-sharing protections under the No Surprises Act or if Your denial is based on a determination that the health care services recommended or requested are experimental or investigational. The Independent Review Organization is composed of persons who are not employed by Us or any of Our affiliates. A decision to request an appeal to an Independent Review Organization will not affect the Insured Person's rights to any other benefits under the plan.

There is no charge for You to initiate this independent review process. We will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a determination by Us regarding medical necessity, clinical appropriateness, healthcare setting, level of care, or effectiveness of the service or treatment that You requested. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, You must submit an appeal request within 180 days of Your receipt of the appeal review denial. Instructions on how to submit an appeal request are included in the decision letter You receive from the Plan.

The Independent Review Organization will render an opinion within 45 days. When requested and when a delay would be detrimental to Your condition, as determined by the Physician reviewer, the review shall be completed within 72 hours.

If You are not fully satisfied with the decision regarding matters that are not eligible for External Review with an Independent Review Organization, You may request an Internal Second Level Grievance review within sixty (60) calendar days of Your receipt of the decision from the Plan.

To file a Second Level Grievance, call, write or fax the Member Appeals Department at the address and telephone numbers listed above. You have the right to present Your Grievance to the committee by way of a conference call. The Second Level Grievance Committee meets and renders a decision on Your standard Grievance appeal within forty-five (45) calendar days from receipt of the second level Grievance appeal. The Second Level Grievance Committee is composed of at least three (3) persons who have had no previous involvement with Your case and who are not subordinates of the person who made the original determination. The Second Level Grievance Committee members will include the Plan's staff, with one third of the committee being Members or other persons who are not employed by the Plan. You may submit supporting materials both before and at the appeal meeting. Additionally, You have the right to review all information considered by the committee that is not confidential, proprietary or privileged. The decision is final unless You choose to appeal to the Pennsylvania Insurance Department or Department of Health as described in the decision letter.

Assistance from the State of Pennsylvania
You have the right to contact the Pennsylvania Insurance Department for assistance at any time. The Pennsylvania Insurance Department may be contacted at the following address and telephone number:

Pennsylvania Insurance Department Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120

Toll-Free Number: 877-881-6388
Fax: 717-787-8585

Notice of Benefit Determination on Appeal
Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information as defined; a statement describing any voluntary appeal procedures offered by the plan; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding Your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist You in the appeal process. A final notice of adverse determination will include a discussion of the decision.

Relevant Information

Relevant Information is any document, record, or other information which: was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Terms of the Policy

Entire Contract
This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by one of Our Officers and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses
After three years from the date coverage is effective under this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such three-year period.

Circumstances Beyond Our Control:
To the extent that a natural disaster, war, riot, civil insurrection, epidemic, or any other emergency or similar event not within Our control results in Our facilities, personnel, or financial resources being unavailable to provide or arrange for Covered Services, We will make a good faith effort to provide or arrange for the provision of the Covered Service taking into account the impact of the event.

Grace Period
You must remit the amounts specified by Us, to Us, pursuant to this Policy, for the applicable period of coverage on or before the first day of each such period of coverage.

If You did not purchase Your Policy from a Marketplace, or You purchased Your Policy from a Marketplace but did not elect to receive advanced Premium tax credit (APTC), there is a grace period of 30 days during which Premiums may be paid without loss of coverage of any Premium due after the first Premium. Coverage will continue during the grace period. Any claims submitted during this grace period will be pended or denied until such time as Your Premium is paid. If We do not receive Your Premium due in full before the end of the grace period, Your coverage will be terminated as of the last date of the Grace Period.

If You purchased Your Policy from a Marketplace and You have elected to receive advanced Premium tax credit (APTC), there is a grace period of ninety (90) consecutive days during which the Premiums may be paid without loss of coverage. Coverage will continue during the grace period, however, claims for services rendered after the first 30 days of the grace period will be either pended or denied until such time as Your Premium is paid. However, if We do not receive Your Premium due in full before the end of the grace period, Your coverage will be terminated as of the last day of the first month of the grace period.

Grace Periods do not apply to Your first month's Premium payment.

Please see the provisions titled "Cancellation" and "Reinstatement" for further information regarding cancellation and reinstatement. In no event shall We have any obligation to provide a reminder notice for Premiums which are not received prior to the expiration of the grace period. Only Insured Persons for whom the payments are actually received by Us shall be entitled to health care services hereunder, and then only for the period for which payment is received.

Cancellation

We may cancel this Policy only in the event of any of the following:

- You fail to pay Your Premiums as they become due or by the end of the last day of the 30-day grace period for plans not purchased from a Marketplace or the 90 consecutive day grace period for plans purchased from a Marketplace.
- On the first of the month following Our receipt of Your written notice to cancel.
- When You become ineligible for this coverage.
- If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
- When We cease to offer policies of this type to all individuals in Your class. In this event, Pennsylvania law requires that We do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual Hospital medical or surgical insurance coverage offered by Us at the time of discontinuation; and (3) act uniformly without regard to any health status related factors of an Insured Person.
- When We cease offering any plans in the individual market in Pennsylvania, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
- When You as the Policyholder no longer lives in the Enrollment Area.
- In the event of entry of a final judgment by a court declaring all or part of the Patient Protection and Affordable Care Act (P.L. 111-148) invalid, unconstitutional, or otherwise ineffective, and the state not providing alternative and sufficient means of funding advanced-Premium tax credits, this Policy shall be subject to cancellation consistent with applicable federal and state law.

Any cancellation shall be without prejudice for any claim for Covered Expenses incurred before cancellation.

Modification of Coverage

We reserve the right to modify this Policy, including Policy provisions, benefits and coverages, so long as such modification is consistent with state or federal law and effective on a uniform basis among all individuals with coverage under this same Policy form. We will only modify this Policy for all Insured Persons in the same class and covered under the same Policy form, and not just on an individual basis. We will send written notice and the change will become effective on the date shown in the notice or on the next scheduled Premium due date thereafter. Payment of the Premiums will indicate acceptance of the change.

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, incentives, or other consideration to You and Your Family Members for the purpose of promoting the general health and well-being of You and Your Family Members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Insured Persons. Incentive programs may be available only to targeted populations and may include cash, cash-in-kind, or other incentives. There is no additional charge for you to access these discount and incentive programs. Contact Us for details regarding any such arrangements.

Reinstatement

If any renewal Premium be not paid within the time granted the insured for payment, a subsequent acceptance of Premium by the insurer or by any agent duly authorized by the insurer to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy: Provided, however, That if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

Note – If the Subscriber receives a Premium tax credit, the Subscriber is not eligible for reinstatement.

Renewal
This Policy renews on a Calendar Year basis.

Fraud
If the Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age
In the event the age of any Insured Person has been misstated in the application for coverage, We shall determine Premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of Premium rate made so that We will be paid the Premium rate appropriate for the true age of the Insured Person.

Certificate of Creditable Coverage
If coverage under this Policy terminates for any Insured Person, We will furnish to that person a Certificate of Creditable Coverage containing the information required by the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191. An Insured Person may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Policy and for 24 months following termination of coverage. To obtain a certificate, call the toll-free member relations number on the back of Your ID card. Such a certificate may help the Insured Person to obtain future coverage. However, We are responsible only for the accuracy of the information contained in any certificate We prepare. We have no responsibility for the determinations made by any other health insurance issuer with respect to any coverage it provides, including whether or not, or to what extent, the information contained in the certificate is relevant to the other health insurance issuer's actions.

Legal Actions
You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 years from the time that proof is required to be given.

Conformity with State and Federal Statutes
If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity
If any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

The Insured Person(s) are the only persons entitled to receive benefits under this Policy.

FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN CANCELLATION OF THIS POLICY AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.

The Effective Date of this Policy is printed on Your identification card and on the Policy specification page.

Identification cards issued by Us to Insured Persons are for identification only. Possession of the card does not guarantee coverage. To be entitled to coverage, the Insured Person must be enrolled and eligible at the time of service.

The **relationship between Us and Participating Providers** who are not employees of Ours are independent contractor relationships. Such Participating Providers are not agents or employees of Ours; and We and Our employees are not agents or employees of such Participating Providers. We are not responsible for any claim for damages or Injuries suffered by an Insured Person while receiving care from any Participating or Non-Participating Provider.

We will meet any notice requirements by mailing the notice to the Insured Person at the billing address listed in Our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any notice requirements by mailing the notice to:

Jefferson Health Plans
1101 Market Street, Suite 3000
Philadelphia, PA 19107

When the amount paid by Us exceeds the amount for which We are liable under this Policy, We have the right to recover the excess amount from the Insured Person unless prohibited by law.

The Covered Services for which benefits are provided under this Policy are limited to the most cost effective and clinically appropriate treatment, supply, or service as defined by Us.

In order for an Insured Person to be entitled to benefits under this Policy, coverage under this Policy must be in effect on the date the expense giving rise to a claim for benefits is incurred. Under this Policy, an expense is incurred on the date the Insured Person(s) receives a service or supply for which the Charge is made.

We will pay all benefits of this Policy directly to Participating Hospitals, Participating Physicians, and all other Participating Providers, whether the Insured Person has authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case We will reimburse the Insured Person. In addition, We may pay any covered Provider of services directly when the Insured Person assigns benefits in writing no later than the time of filing proof of loss (claim), except for foreign country Provider claims. However, We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Family Member(s), You or Your Family Member(s) are responsible for reimbursing the Provider and Our payment to You will be considered fulfillment of Our obligation.

If We receive a claim from a foreign country Provider for an Emergency Medical Condition, any eligible payment will be sent to the Insured Person. The Insured Person is responsible for paying the foreign country Provider. These payments fulfill Our obligation to the Insured Person for those services.

Any payment of benefits in reimbursement for Covered Expenses paid by an eligible child, or the eligible child's custodial parent or legal guardian, will be made to the eligible child, the eligible child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the eligible child.

We will provide written notice to You within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any Provider contract, if We determine that You or Your Family Member(s) may be materially and adversely affected.

We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or needs a new Provider listing for any other reason, please call Us at the number on the ID card and We will provide the Insured Person with one, or You can visit Our website and view Our online directory at https://www.jeffersonhealthplans.com/individuals-families/
Failure by Us to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.

If Insured Person(s) were covered by a prior Individual policy of Ours that is replaced by this Policy with no lapse of coverage, benefits used under the prior policy will be charged against the benefits payable under this Policy.

We reserve the right to: (i) change the rates chargeable under the Policy and (ii) amend the terms of this Policy to eliminate, alter, or modify provisions required only by the Patient Protection and Affordable Care Act (P.L. 111-148) in the event of either (a) entry of a final judgment by a court declaring all or part of the law invalid, unconstitutional, or otherwise ineffective or (b) amendments to the law by legislative act.

Physical Examination and Autopsy: We, at Our own expense, shall have the right and the opportunity to examine any Insured Person for whom a claim is made, when and so often as We may reasonably require during the pendency of a claim under this Policy. In the case of death of an Insured Person, We shall have the right and opportunity to make an autopsy where it is not prohibited by law.

Other Insurance with This Insurer

If while covered under this Policy, the Insured Person(s) is also covered by another one of Our individual or group policy, the Insured Person(s) will be entitled to the benefits of only one policy. Insured Person(s) may choose this Policy or the policy under which Insured Person(s) will be covered. We will then refund any Premium received under the other policy covering the time period both policies were in effect.

However, any claims payments made by Us under the policy You elect to cancel will be deducted from any such refund of Premium.

How to File a Claim for Benefits

Notice of Claim

There is no paperwork for claims for services from Participating Providers. You will need to show Your ID card and pay any applicable Copayment; Your Participating Provider will submit a claim to Us for reimbursement. Claims for Emergency Services from Non-Participating Providers can be submitted by the Provider if the Provider is able and willing to file on Your behalf. If a Non-Participating Provider is not submitting on Your behalf, You must send Your completed claim form and itemized bills to the claims address listed on Your ID card.

Claim Forms

You may get the required claim forms from https://www.jeffersonhealthplans.com/individuals-families/ under Health Care Providers, Coverage and Claims, or by calling Member Relations using the toll-free number on Your identification card.

Claim Reminders:

- Be sure to use Your member ID and account number when You file claim forms, or when You call Our claim office.

Your member ID is shown on Your ID card.

  - Your group number is the 8-digit number shown on Your ID card.
- Be sure to carefully follow the instructions listed on the back of the claim form when submitting a claim.

Proof of Loss

Claims cannot be paid until a written proof of loss is submitted to the Plan. Written proof of loss must be provided to the Plan within ninety (90) days after the charge for Covered Services is Incurred. Proof of loss must include all data necessary for the Plan to determine benefits. Failure to submit a proof of loss to the Plan within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will the Plan be required to accept a proof of loss later than one (1) year after the charge for Covered Services is Incurred.

Assignment of Claim Payments

Medical benefits are assignable to the Provider; when You assign benefits to a Provider, You have assigned the entire amount of the benefits due on that claim. If the Provider is overpaid because of accepting a patient's payment on the Charge, it is the Provider's responsibility to reimburse the patient. Because of Our contracts with Providers, all claims from contracted Providers should be assigned.

We will recognize and consider any assignment made under the Policy, only if:

- It is duly executed on a form acceptable to Us;
- A copy is on file with Us; and
- It is made by a Provider licensed and practicing within the United States.

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Family Member(s), You or Your Family Member(s) are responsible for paying the Non-Participating Provider and Our payment to You will be considered fulfillment of Our obligation.

We assume no responsibility for the validity or effect of an assignment.

Timely Payment of Claims

Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims

Any benefits payable under this Policy for Covered Services provided by a Participating Provider will be paid directly to that Participating Provider unless You direct otherwise, in writing, by the time proofs of loss are filed. Any benefits payable under this Policy for Covered Services provided by a Non-Participating Provider will be paid directly to You unless You direct otherwise, in writing, by the time proofs of loss are filed. In the event of Your death, We will issue any benefits payable to You to the beneficiary of Your estate as determined by applicable law.

Claim Determination Procedures Under Federal Law (Provisions of the laws of this state may supersede.)

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the Policy. The procedures for determining medical necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical necessity determinations are made on either a pre-service, concurrent, or post-service basis, as described below.

Certain services require Prior Authorization in order to be covered. This Prior Authorization is called a "pre-service medical necessity determination." The Policy describes who is responsible for obtaining this review. The Insured Person or their authorized representative (typically, their health care Provider) must request medical necessity determinations according to the procedures described below, in the Policy, and in the Insured Person's Provider's network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, the Insured Person or their representative will receive a written description of the adverse determination and may appeal the determination. Appeal procedures are described in the Policy, in the Insured Person's Provider's network participation documents, and in the determination notices.

Pre-service Medical Necessity Determinations

When the Insured Person or their representative requests a required medical necessity determination prior to care, We will notify the Insured Person or their representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Our control, We will notify the Insured Person or their representative within 15 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information to Us within 45 days after receiving the notice. The determination period will be suspended on the date We send such a notice of missing information, and the determination period will resume on the date the Insured Person or their representative responds to the notice.

If the determination periods above would (a) seriously jeopardize the Insured Person's life or health, their ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Insured Person's health condition, cause them severe pain which cannot be managed without the requested services, We will make the pre-service determination on an expedited basis. Our Physician reviewer, in consultation with the treating Physician, will decide if an expedited determination is necessary. We will notify the Insured Person or their representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, We will notify the Insured Person or their representative within 24 hours after receiving the request to specify what information is needed. The Insured Person or their representative must provide the specified information to Us within 48 hours after receiving the notice. We will notify the Insured Person or their representative of the expedited benefit determination within 48 hours after the Insured Person or their representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If the Insured Person or their representative fails to follow Our procedures for requesting a required pre-service medical necessity determination, We will notify them of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the Insured Person or their representative requests written notification.

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for an Insured Person and they wish to extend the approval, the Insured Person or their representative must request a required concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the Insured Person or their representative requests such a determination, We will notify them of the determination within 24 hours after receiving the request.

Post-service Medical Necessity Determinations

When an Insured Person or their representative requests a Medical Necessity determination after services have been rendered, We will notify them of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Our control, We will notify the Insured Person or their representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information to Us within 45 days after receiving the notice. The determination period will be suspended on the date We send such a notice of missing information, and the determination period will resume on the date the Insured Person or their representative responds to the notice.

Post-service Claim Determinations

When an Insured Person or their representative requests payment for services which have been rendered, We will notify them of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Our control, We will notify the Insured Person or their representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date We send such a notice of missing information, and resume on the date the Insured Person or their representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination:

- Information sufficient to identify the claim;
- The specific reason or reasons for the adverse determination;
- Reference to the specific plan provisions on which the determination is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- Upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding Your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, Experimental treatment or other similar exclusion or limit;
- Information about any office of health insurance consumer assistance or ombudsman available to assist You with the appeal process; and
- In the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Premiums

The monthly Premium amount is listed on the Policy specification page which was sent with this Policy.

You will be responsible for an additional $45 charge for any check or electronic funds transfer that is returned to Us unpaid. This additional charge is part of Your Premium obligation. You will not be considered to have paid Your Premium until Your Premium amount and any additional charges incurred by You are received by Us.

Your Premium may change due to (but not limited to):

- Deletion or addition of a new eligible Insured Person(s).
- A change in age of any Insured Person which results in a higher Premium.
- A change in residence.
- Application of any additional charges as a result of a late or returned payment.

These changes will be effective on the first of the month following the change, unless as otherwise stated on Your Premium notice.
We also reserve the right to change the Premium on 30 days' prior written notice to You. However, We will not modify the Premium schedule on an individual basis, but only for all Insured Persons in the same class and covered under the same Policy as You. The change will become effective on the date shown on the notice, and payment of the new Premiums will indicate acceptance of the change.

Premiums are to be paid by You to Us.

We will not accept the direct or indirect payment of Premiums by any person or entity other than You, Your family members or an Acceptable Third Party Payor, except as expressly permitted by Us in writing. We may request and upon request, You shall provide, a certified statement from You that You are not receiving payment or other remuneration from anyone other than an Acceptable Third Party Payor as defined above for the partial or full payment of Your Premium or other cost-sharing obligations under this Policy.

REQUIRED OUTLINE OF COVERAGE FOR INDIVIDUAL
HMO SUBSCRIBER AGREEMENT ISSUED BY

Health Partners Plans, Inc.
d.b.a. Jefferson Health Plans

(Heretoafter and for purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc.)

1101 Market Street, Suite 3000
Philadelphia, PA 19107

Jefferson Health Plans HMO

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Jefferson Health Plans. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Major Medical Expense Coverage—Policies of this category are designed to provide, to persons insured, coverage for major Hospital, medical, and surgical expenses incurred as a result of a covered accident or Sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, in-Hospital medical services, out of Hospital care, and prosthetic appliances, subject to any Deductibles Copayment or Coinsurance provisions, or other limitations which may be set forth in the Plan.

Brief Description of Coverage—Subject to the Exclusions, limitations, and conditions of the Policy, a Member is entitled to benefits for Covered Services during a Benefit Period, subject to cost-sharing amounts as specified in the Schedule of Benefits.

This Plan does not cover services provided by or goods obtained from an Out-of-Network Provider, with the exception of Emergency Services and Services provided by an Out-of-Network provider received at an In-Network facility, which are paid at the In-Network level of benefits regardless of the Provider or Facility's Network status.

This coverage utilizes Preapproval and utilization management procedures, which must be followed in order for services to be considered for coverage. The percentages for your Coinsurance and Allowed Amounts shown below are not always calculated on actual charges. For an explanation on how coinsurance is calculated, see the "Allowed Amount" definition below.

Allowed Amount refers to the basis on which a Member's Coinsurance, Out-of-Pocket Maximum and benefits are calculated.
A. For services provided by a Participating Facility Provider, the term "Allowed Amount" is the Health Plan's fee schedule amount.
B. For services provided by a Participating Professional Provider, "Allowed Amount" is the Health Plan's fee schedule amount.
C. For services provided by Participating Ancillary Service Providers, "Allowed Amount" means the amount that the Health Plan has negotiated with the Participating Ancillary Service Provider as total reimbursement for the Covered Services.

Individual Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services each Year before benefits are available under this Policy. The amount of the Individual Deductible is described in the benefit schedule section of the Policy. The deductible may not apply to all services, including preventative services. The Deductible applies to all Covered Expenses, except for those covered under the Prescription Drugs section of this Policy; if there is a separate Prescription Drug Deductible that applies only to those benefits.

Family Deductible applies if You and one or more of Your Family Member(s) are enrolled for coverage under the Policy. It is an accumulation of the Individual Deductibles paid by each Family Member during a Year. Each Insured Person can contribute up to the Individual Deductible amount toward the Family Deductible. Once the Family Deductible amount is satisfied in a Year, any remaining Individual Deductibles will be waived for the remainder of the Year. The Family Deductible applies to all Covered Expenses, except for those covered under the Prescription Drug section of this Policy; if there is a separate Prescription Drug Deductible that applies only to those benefits. The amount of the Family Deductible is described in the benefit schedule section of the Policy.

Individual Out-of-Pocket Maximum: The Individual Out-of-Pocket Maximum is an accumulation of Covered Expenses. It includes Deductibles, Copayments and Coinsurance for medical and Prescription Drug Covered Services. Once the Out-of-Pocket Maximum has been met for the Year, for Covered Expenses, you will no longer have to pay any Coinsurance or Copayment for medical or Pharmacy services for Covered Expenses incurred during the remainder of that Year. Non-compliance penalty charges do not apply to the Individual Out-of-Pocket Maximum and will always be paid by you. The amount of the Individual Out-of-Pocket Maximum is described in the benefit schedule section of the Policy.

Family Out-of-Pocket Maximum: applies if You and one or more of Your Family Member(s) are enrolled for coverage under the Policy. It is an accumulation of the Deductible, Coinsurance and Copayments each Family Member has accrued during a Year. Each Insured Person can contribute up to his or her Individual Out-of-Pocket amount toward the Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum has been met in a Year, You and Your Family Member(s) will no longer be responsible to pay Coinsurance or Copayments for medical or Pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. The amount of the Family Out-of- Pocket Maximum is described in the benefit schedule section of the Policy.

Participating Provider (In-Network Provider) means:

- Hospitals, Physicians, and Other Health Care Facilities or Professionals which are: (i) licensed in accordance with any applicable Federal and state laws, (ii) accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another organization, if applicable, and (iii) acting within the scope of the practitioner's license and accreditation, and have contracted with Us to provide services to Insured Persons; or

- For the purposes of reimbursement for Covered Expenses, an entity that has contracted with Us to arrange, through contracts with Providers for the provision of any services and/or supplies, the Charges for which are Covered Expenses.

Non-Participating Provider (Out-of-Network Provider) is a Provider who does not have a Participating Provider agreement in effect with Us at the time services are rendered.

BENEFIT SCHEDULE

Health Partners Plans, Inc
d.b.a. Jefferson Health Plans

Jefferson Health Plans + Total + Silver + HMO + No Cost Sharing

BENEFIT SCHEDULE		
You are entitled to benefits for the Covered Services described in your Agreement, subject to any cost sharing or Limitations described below. If the Participating Provider's usual fee for a Covered Service is less than the cost sharing amount shown in this Schedule, you are only responsible to pay the Participating Provider's usual fee. The Participating Provider is required to remit any cost sharing overpayment amount directly to you. If you have any questions, contact Customer Service at the phone number on your ID Card. This plan has a Tiered Network. For the purpose of this Program, each benefit tier (shown in the columns below) refers to your cost share based on the tier level of the Participating Provider you receive services from. Providers included in each tier (Enhanced or Standard) are part of a selected subset of the HMO's entire network of Participating Providers. For services received as a result of an Emergency, if the Member is admitted to a Participating Hospital from the Emergency Room, the cost- sharing for inpatient hospital care, including Medical Care provided by a Participating Professional Provider, will apply based on the tier level of that provider, whether the provider is a Participating Hospital or a Participating Professional Provider. Non-Participating Providers for Emergency and Out- of-Area Urgent Care Services, to the extent the Urgent Care services are Emergency services, will be reimbursed pursuant to the methodology established by the Consolidated Appropriations Act (CAA). The Member will be subject to the Tier 1 Enhanced in-network cost-sharing levels. To find a list of Participating Providers with their designations, log onto the HMO website at https://www.jeffersonhealthplans.com/individuals-families/, or you can call Customer Service at the phone number listed on your ID Card to have a Provider Directory mailed to you.		
Benefit Period: Your Benefit Period is a Calendar Year (1/1 – 12/31).		
	TIER 1 ENHANCED	**TIER 2 STANDARD**
ANNUAL DEDUCTIBLE		
Per Member	$0	$0
Per Family	$0	$0

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

The Family Deductible will be applied for all family members covered under a Family coverage. It will not be applied to any covered individual family Member once that covered individual has satisfied the Deductible for that Benefit Period, or the Family Deductible has been satisfied for all covered family Members combined. The Deductible under this tiered plan is an aggregate of any Deductibles paid under all Tiers for which a Deductible applies. For example, any Deductibles paid when the Member receives services from Tier 2 Providers are combined to apply toward the Annual Deductible listed above.

	TIER 1 ENHANCED	TIER 2 STANDARD
OUT-OF-POCKET MAXIMUM		
Per Member	$0	
Per Family	$0	
The Out-of-Pocket Maximum is the maximum dollar amount that a Member pays for Covered Services within a Benefit Period. The Out-of-Pocket Maximum includes Coinsurance, Copayment and/or Deductible amounts, if applicable, for Essential Health Benefits; it does not include any amounts above the Allowed Amount for a specific Provider, or the amount for any services not covered under this Subscriber Agreement. Amounts paid for Covered Services received under Tiers 1, and 2 will be applied and accumulate concurrently towards the Out-of-Pocket maximum.		
	TIER 1 ENHANCED	**TIER 2 STANDARD**
COINSURANCE PERCENTAGE	0%	0%
Coinsurance is applied to some of the Covered Services listed below, but not to Covered Services that require the Member to pay a Copayment amount. Coinsurance is a percentage of the Covered Service that must be paid by the Member; it is applied after the Deductible is met in each Benefit Period. A Deductible may also apply to certain services that are subject to a Copayment. Those services that are subject to a Deductible with a Copayment are identified below. The Member will also be responsible to pay costs for services that are not covered by the Plan.		
LIFETIME BENEFIT MAXIMUM	Unlimited	
PRIMARY AND PREVENTIVE CARE COVERED SERVICES COST SHARING & LIMITATIONS		
BENEFIT	**COST SHARING**	
	TIER 1 ENHANCED	**TIER 2 STANDARD**
OFFICE VISITS/VIRTUAL VISITS TO YOUR PCP (Non-Preventive)		

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

Office Visits	$0	$0
Virtual Visits	$0	$0
Note for Office Visits/Virtual Visits to your PCP shown above: If a Member receives Covered Services in addition to an office visit, additional Copayments, Deductibles or Coinsurance may apply		

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

PRIMARY AND PREVENTIVE CARE COVERED SERVICES COST SHARING & LIMITATIONS (continued)		
BENEFIT	**COST SHARING**	
	TIER 1 ENHANCED	**TIER 2 STANDARD**
OFFICE VISITS/VIRTUAL VISITS TO A SPECIALIST		
Office Visits	$0	$0
Virtual Visits	$0	$0
Note for Office Visits/Virtual Visits to a Specialist shown above: If a Member receives Covered Services in addition to an office visit, additional Copayments, Deductibles or Coinsurance may apply		
PEDIATRIC PREVENTIVE CARE		
IMMUNIZATIONS	$0	
ADULT PREVENTIVE CARE	$0	
WOMEN'S PREVENTIVE HEALTH CARE (Includes Routine Gynecological Exam, Pap Smear, one (1) per Benefit Period, all ages)	$0	
MAMMOGRAMS	$0	
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT	$0	
Six (6) Outpatient nutrition counseling visits/sessions per Benefit Period		
SMOKING CESSATION Two attempts per year	$0	

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

INPATIENT COVERED SERVICES COST SHARING & LIMITATIONS		
BENEFIT	**COST SHARING/LIMITATIONS**	
	TIER 1 ENHANCED	**TIER 2 STANDARD**
HOSPITAL SERVICES **Inpatient and Emergency Admissions***	$0	$0
MEDICAL CARE **Inpatient Professional Service**	$0	$0
Note for Medical Care Services shown above: This policy does not cover charges incurred for services provided by Non-Participating Providers except when received from a Hospital-Based Provider (including anesthesiologists, radiologist, pathologists, and other ancillary providers) while you are an Inpatient at a Participating Hospital or receiving outpatient Covered Services at a Participating Facility.		
SKILLED NURSING CARE FACILITY*	$0	$0
Note for Skilled Nursing Facility Services shown above: Maximum of One hundred twenty (120) Inpatient days per Benefit Period.		

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS		
BENEFIT	**COST SHARING/LIMITATIONS**	
	TIER 1 PREFERRED	**TIER 2 ENHANCED**
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES (including Detoxification)		
Inpatient*	$0	$0
Outpatient		
Office Visit	$0	
All Other	$0	

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)		
BENEFIT	**COST SHARING/LIMITATIONS**	
	TIER 1 ENHANCED	**TIER 2 STANDARD**
AUTISM SPECTRUM DISORDERS **Diagnosis and Treatment of Autism Spectrum Disorder**	Same cost-sharing as any other Covered Service within the applicable medical service category (For example, Specialist, Hospital Services, Therapy Services, etc.)	
Gender Affirming Care	$0	$0
HOSPICE SERVICES **Inpatient Hospice Services**	$0	$0
Outpatient Hospice Services **Professional Service**	$0	$0
MATERNITY/OBSTETRICAL – GYNECOLOGICAL/FAMILY SERVICES		
Abortion Services **Professional Service**	$0	$0
Outpatient Facility Services **Ambulatory Surgical Facility**	$0	$0
Outpatient Hospital-Based Facility	$0	$0
Services limited to pregnancies as a result of rape or incest, or to avert the death of the mother		

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)		
BENEFIT	**COST SHARING/LIMITATIONS**	
	TIER 1 ENHANCED	**TIER 2 STANDARD**
MATERNITY/OBSTETRICAL – GYNECOLOGICAL/FAMILY SERVICES ***(Continued)***		
Facility Services- Inpatient/Birthing Center *	$0	$0
Newborn Care	$0 **Not** Subject to Deductible	
Artificial Insemination	$0	$0
Maternity/Obstetrical Care **Professional Service**	$0	$0

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)		
BENEFIT	**COST SHARING/LIMITATIONS**	
	TIER 1 ENHANCED	**TIER 2 STANDARD**
SURGICAL SERVICES **Inpatient Professional Services**	$0	$0
Outpatient Facility Charges	$0	$0
Ambulatory Surgical Facility	$0	$0
Outpatient Hospital-Based Facility	$0	$0
Outpatient Anesthesia	$0	$0
Voluntary Second Surgical Opinion	$0	$0
Office Visits	$0	$0
ORGAN AND TISSUE TRANSPLANT SERVICES		
Inpatient Transplant Services Facility Fee Professional Fee	$0	$0
Outpatient Transplant Services Facility Fee Professional Fee	$0	$0

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS		
BENEFIT	**COST SHARING/LIMITATIONS**	
	TIER 1 ENHANCED	**TIER 2 STANDARD**
AMBULANCE SERVICES/TRANSPORT	$0	
DAY REHABILITATION PROGRAM **PT/OT Outpatient Visits** Thirty (30) visits per Benefit Period **Speech Outpatient Visits** Thirty (30) visits per Benefit Period	$0	$0
Thirty (30) visits per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Substance Use Disorder, or Autism Spectrum Disorders.		
DENTAL, ACCIDENTAL INJURY	$0	$0
Dental Anesthesia	$0	$0
Limited to those seven years of age or younger or developmentally disabled for whom a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected for treatment under general anesthesia.		
DIABETIC EDUCATION PROGRAM	$0	
DIABETIC EQUIPMENT AND SUPPLIES	$0	$0
DIAGNOSTIC SERVICES **Routine Radiology/Diagnostic Services**		
Freestanding	$0	$0
Hospital-based	$0	$0
Non-Routine Diagnostic Services (including MRI/MRA, CT/CTA scans, PET scans)		
Freestanding	$0	$0

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

Hospital-based	$0	$0
OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)		
BENEFIT	**COST SHARING/LIMITATIONS**	
	TIER 1 ENHANCED	**TIER 2 STANDARD**
Diabetes Care Management	$0	$0
DURABLE MEDICAL EQUIPMENT AND CONSUMABLE MEDICAL SUPPLIES **(including PROSTHETIC DEVICES and ORTHOTICS)**	$0	$0

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

OUTPUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)		
BENEFIT	**COST SHARING/LIMITATIONS**	
	TIER 1 ENHANCED	**TIER 2 STANDARD**
EMERGENCY CARE – Facility	$0	
Non-Participating Providers for Emergency and Out-of-Area Urgent Care Services, to the extent the Urgent Care services are Emergency services will be reimbursed pursuant to the methodology established by the Consolidated Appropriations Act (CAA). The Member will be subject to the Tier 1 Enhanced in- network cost-sharing levels.		
HABILITATIVE SERVICES		
Physical Therapy/Occupational Therapy		
Freestanding	$0	$0
Hospital-based	$0	$0
Thirty (30) visits per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Substance Use Disorder, or Autism Spectrum Disorders.		
There is no visit limit for lymphedema therapy related to a mastectomy.		
Speech Therapy	$0	$0
Thirty (30) visits per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.		
HOME HEALTH CARE	$0	$0
Maximum of Sixty (60) visits per Benefit Period. Special or Private Duty Nursing Not Included.		

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

OUTPUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)		
BENEFIT	**COST SHARING/LIMITATIONS**	
	TIER 1 ENHANCED	**TIER 2 STANDARD**
INJECTABLE MEDICATIONS **Standard Injectable Drugs (includes Allergy Injections)**	$0	$0
Biotech/Specialty Drugs	$0	
Home/Office	$0	$0
Outpatient	$0	$0
LABORATORY AND PATHOLOGY TESTS (includes Allergy Testing)		
LabCorp and Independent Labs	$0	$0
Hospital-Based	$0	$0
MEDICAL CARE **Outpatient Professional Services**	$0	$0
MEDICAL FOODS AND NUTRITIONAL FORMULAS	$0	
Note for Medical Care Services shown above: This policy does not cover charges incurred for services provided by Non-Participating Providers except when received from a Hospital-Based Provider (including anesthesiologists, radiologist, pathologists, and other ancillary providers) while you are an Inpatient at a Participating Hospital or receiving outpatient Covered Services at a Participating Facility.		

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)		
BENEFIT	**COST SHARING/LIMITATIONS**	
	TIER 1 ENHANCED	**TIER 2 STANDARD**
REHABILITATIVE SERVICES		
Physical Therapy/Occupational Therapy		
Freestanding	$0	$0
Hospital-based	$0	$0
Thirty (30) visits per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Substance Use Disorder, or Autism Spectrum Disorders.		
There is no visit limit for lymphedema therapy related to a mastectomy.		
Speech Therapy	$0	$0
Thirty (30) visits per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Substance Use Disorder, or Autism Spectrum Disorders.		
SPINAL MANIPULATION THERAPY Twenty (20) visits per Benefit Period	$0	$0
THERAPY SERVICES **Cardiac Rehabilitation Therapy** Thirty-six (36) visits per Benefit Period	$0	$0
Chemotherapy	$0	$0
Dialysis	$0	$0

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)		
BENEFIT	**COST SHARING/LIMITATIONS**	
	TIER 1 ENHANCED	**TIER 2 STANDARD**
Infusion Therapy		
Home/Office	$0	$0
Outpatient	$0	$0
Pulmonary Rehabilitation Therapy Thirty-six (36) visits per Benefit Period	$0	$0
Radiation Therapy	$0	$0
Respiratory Therapy	$0	$0
URGENT CARE CENTER - Facility	$0	$0

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)		
BENEFIT	**FOR BENEFITS PROVIDED BY CONTRACTED VENDORS:**	
	TIER 1 ENHANCED	**TIER 2 STANDARD**
VIRTUAL CARE SERVICES		
Telemedicine Visit	$0	
Teledermatology	$0	
Telebehavioral Health	$0	

Inpatient Copayment Waiver Provision
*The Inpatient Copayment as stated in this Schedule applies to each admission, readmission or transfer of a Member for Covered Services for Inpatient treatment of any condition. For purposes of calculating the total Copayment due, any admission occurring within ten (10) days of discharge from any previous admission shall be treated as part of the previous admission

PRESCRIPTION DRUG COST SHARING & LIMITATIONS	
BENEFIT	**COST SHARING/LIMITATIONS (per 30 day supply)**
PRESCRIPTION DRUG DEDUCTIBLE: Deductible must be met before applicable Coinsurance amounts are applied, unless noted otherwise below. The Prescription Drug Family Deductible will be applied for all family members covered under a Family coverage. It will not be applied to any covered individual family Member once that covered individual has satisfied the Prescription Drug Deductible for that Benefit Period, or the Prescription Drug Family Deductible has been satisfied for all covered family members combined.	
Per Individual	$0
Per Family	$0
Participating Retail Pharmacy**	$0
Low-Cost Generic Drugs	$0
Generic Drug	$0
Preferred Brand Drug	$0
Non-Preferred Drug	$0

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

PRESCRIPTION DRUG COST SHARING & LIMITATIONS (Continued)	
BENEFIT	**COST SHARING/LIMITATIONS (per 30 day supply)**
Participating Retail Pharmacy (continued)**	
Specialty Drug***	50% for Covered Drugs or Supplies up to $1,000 maximum after Prescription Drug Deductible
Participating Mail Service Pharmacy†	
The amount of your cost sharing is determined by the days-supply you receive of a Covered Maintenance Drug:	
For a 1-30 days-supply:	
Low-Cost Generic Drugs	$0
Generic Drug	$0
Preferred Brand Drug	$0
Non-Preferred Drug	$0
For a 31-90 days-supply:	
Low-Cost Generic Drugs	$0
Generic Drug	$0
Preferred Brand Drug	$0
Non-Preferred Drug	$0

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

PRESCRIPTION DRUG COST SHARING & LIMITATIONS (Continued)
The pharmacy benefits manager's (PBM's) preferred Retail Pharmacy network is a subset of the national retail pharmacy network and includes most major chains and local pharmacies. To verify that a Retail Pharmacy is participating in the preferred Retail Pharmacy network, call the Customer Service telephone number shown on the Member's Identification Card. Out-of-Network benefits apply to prescriptions filled at non-preferred Retail Pharmacies and the Member will pay the full retail price for their prescription then file a paper claim for reimbursement. * The cost-sharing amounts for a specialty drug prescription or for certain other high-cost Prescription Drugs set forth above are applicable to those Prescription Drugs dispensed to a Member who does not receive cost-sharing assistance such as coupons/copay cards provided by a drug manufacturer. In the event a Member does elect to receive such cost-sharing assistance, amounts paid or credited by a drug manufacturer on behalf of a Member will not accrue toward the satisfaction of the Member's Program Deductible or Out-of-Pocket Limit. † 31-90 day supplies of Prescription Drugs to treat chronic conditions are available at the Participating Mail Service Pharmacy and a designated retail pharmacy.

PRESCRIPTION DRUG LIMITATIONS

A description of limitations for your Covered Drugs Or Supplies is described below:

1. Not covered are drugs not appearing on the Drug Formulary, except where an exception has been granted pursuant to the Formulary Exception Policy. Regardless of tier level, Non-Formulary Generic and Brand drugs are subject to any drug deductible.

2. A pharmacy need not dispense a Prescription Order which, in the Pharmacist's professional judgment, should not be filled, without first consulting with the prescribing Physician.

3. The quantity of a Covered Drug or Supply dispensed pursuant to a Prescription Order or Refill is limited to thirty (30) consecutive days or the maximum allowed dosage as Prescribed by law, whichever is less.

   Up to a ninety (90) day supply of a Maintenance Prescription Drug may be obtained through a Participating Mail Service Pharmacy for the Prescription Drug cost sharing as shown on this Schedule.

4. Members must present their Identification Card, and the existence of Prescription Drug coverage must be indicated on the card.

5. A Member shall pay to a Participating Pharmacy:

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

PRESCRIPTION DRUG LIMITATIONS (Continued)

A. One hundred percent (100%) of the cost for a Prescription Drug dispensed when the Member fails to show their Identification Card;
B. One hundred percent (100%) of a non-Covered Drug or Supply; or
C. The applicable Prescription Drug cost sharing; or
D. When a Prescription Drug is available in a Generic Drug form, the Plan will only provide benefits for that Prescription Drug at the Generic Drug level. If the prescribing Physician indicates that the Brand Name Drug should be dispensed, a non-formulary Brand Name Drug is approved due to medical necessity, or if the Member requests a Brand Name Drug, the Member shall be responsible for paying the dispensing Pharmacy the difference between the amount for the Generic Drug and the Brand name Drug, plus the appropriate Member cost share amount. To address any questions regarding the Member's pharmacy benefit call the Customer Service telephone number on the back of the Member's Identification Card.

6. In certain cases the Plan may determine that the use of certain Covered Drugs or Supplies for a Member's medical condition requires prior authorization for Medical Necessity.

7. The Plan reserves the right to apply dispensing limits for certain Covered Drugs or Supplies as conveyed by the FDA or the Plan's Pharmacy and Therapeutics Committee.

8. The dollar amount paid by a third party will not accumulate toward any applicable Deductible or Out-of-Pocket Maximum to the extent permitted by law.

Note for Prescription Drug shown above: Contraceptives mandated by the Women's Preventive Services provision of PPACA, are covered at 100% when obtained at a Participating Pharmacy or a Participating Mail Service Pharmacy for certain generic products and brand products. All other contraceptive products are covered at standard cost-sharing as reflected in this Section SC - Schedule of Cost Sharing & Limitations.

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

PEDIATRIC VISION COST SHARING & LIMITATIONS	
BENEFIT	**COST SHARING/LIMITATIONS ***
* Annual Deductible does not apply to Pediatric Vision benefits	
VISION CARE	
Participating Provider	
Routine Eye Exam & Refraction	$0 Once every Benefit Period
Frames and Prescription Lenses	$0 Three every Benefit Period
Medically Necessary Contact Lenses (in lieu of eyeglasses or elective contact lenses) including Standard, Specialty and Disposable Lenses (with prior approval)	$0
Non-Participating Provider	Not Covered

[1]Heretoafter and for the purposes of this document, all references to Jefferson Health Plans also include Health Partners Plans, Inc

<u>Excluded Services</u>
In addition to any other exclusions and limitations described in this Policy, there are no benefits provided for the following:

1. **Services obtained from a Non-Participating/Out-of-Network Provider**, except for treatment of an Emergency Medical Condition or for non-emergency care provided by an out-of-network provider at an in-network facility.
2. Any **amounts in excess of maximum benefit limitations of Covered Expenses** stated in this Policy.
3. Services **not specifically listed as Covered Services** in this Policy.
4. Services or supplies that are **not Medically Necessary except for Preventive Services**.
5. Services, items or supplies that are considered to be Experimental **Procedures or Investigational Procedures or Unproven Procedures**.
6. **Services** received before the Effective Date of coverage**.**
7. **Services** received after coverage under this Policy ends**.**
8. Services **for which You have no legal obligation to pay** or for which no charge would be made if You did not have a health plan or insurance coverage.
9. Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, **under any workers' compensation, employer's liability law or occupational disease law**, even if the Insured Person does not claim those benefits.
10. Conditions caused by: (a) an **act of war (declared or undeclared)**; (b) the **inadvertent release of nuclear energy** when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person **participating in the military service of any country**; (d) an Insured Person **participating in an insurrection, rebellion, or riot;** (e) services received as a direct result of an Insured Person's commission of, or attempt to commit a **felony** (whether or not charged) **or as a direct result of the Insured Person being engaged in an illegal occupation;** (f) an Insured Person being intoxicated, as defined by applicable state law in the state where the Illness occurred or under the influence of illegal narcotics or non-prescribed controlled substances unless administered or prescribed by Physician.
11. Any **services provided by a local, state or federal government agency**, except when payment under this Policy is expressly required by federal or state law.
12. Any services required by state or federal law to be supplied by a public school system or school district.
13. Any **services for which payment may be obtained from any local, state or federal government agency** (except Medicaid). Veterans Administration Hospitals and military treatment facilities will be considered for payment according to current legislation.
14. **If the Insured Person is eligible for Medicare** Part A, B, C or D, We will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount We would have paid if it were the sole insurance carrier.
15. **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician and listed as covered in this Policy.

16. Professional **services or supplies received or purchased directly or on Your behalf by anyone, including a Physician, from** any of the following:
    a. Yourself or Your employer;
    b. A person who lives in the Insured Person's home, or that person's employer;
    c. A person who is related to the Insured Person by blood, marriage or adoption, or that person's employer; or
    d. A facility or health care professional that provides remuneration to You, directly or indirectly, or to an organization from which You receive, directly or indirectly, remuneration.
17. Services of a Hospital emergency room **for any condition that is not an Emergency Medical Condition** as defined in this Policy.
18. Custodial Care, including but not limited to rest cures; infant, child or adult day care, including geriatric day care**.**
19. **Private duty nursing** except when provided as part of the home health care services or Hospice Care Services benefit in this Policy.
20. Inpatient room and board **charges in connection with a Hospital stay primarily for environmental change or Physical Therapy.**
21. Services received during **an inpatient stay when the stay is primarily related to** behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of a Mental Health Disorder.
22. **Complementary and alternative medicine services, including but not limited to**: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; meditation; visualization; acupuncture; acupressure; acupuncture point injection therapy; reflexology; rolfing; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy; hypnosis; energy-balancing; breathing exercises; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf; and any other alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. Services specifically listed as covered under "Rehabilitative Therapy" and "Habilitative Therapy" are not subject to this exclusion.
23. Any services or supplies **provided by or at a place for the aged, a nursing home, or any facility** a significant portion of the activities of which include rest, recreation, leisure, or any other services that are not Covered Services.
24. **Assistance in activities of daily living**, including but not limited to: bathing, eating, dressing, or other Custodial Care, self-care activities or homemaker services, and services primarily for rest, domiciliary or convalescent care.
25. **Services performed by unlicensed practitioners** or services which do not require licensure to perform, for example meditation, breathing exercises, guided visualization.
26. Inpatient room and board **charges in connection with a Hospital stay primarily for diagnostic tests** which could have been performed safely on an outpatient basis.

27. **Dental services**, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
28. **Orthodontic services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
29. **Dental implants**: dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
30. Any services covered under **both this medical plan and an accompanying exchange-certified pediatric dental plan** and reimbursed under the dental plan will not be reimbursed under this plan.
31. **Hearing aids** including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as specifically stated in this Policy, limited to the least expensive professionally adequate device. For the purposes of this exclusion, a hearing aid is any device that amplifies sound.
32. **Routine hearing tests** except as provided under Preventive Care.
33. For **assisted fertilization techniques** such as, but not limited to, in vitro fertilization; embryo transplant; ovum retrieval, including gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and any services required in connection with these procedures.
34. **Genetic screening**: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
35. **Gene Therapy** including, but not limited to, the cost of the Gene Therapy product, and any medical, surgical, professional and facility services directly related to the administration of the Gene Therapy product.
36. **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision Care.
37. Eye **surgery solely for the purpose of correcting refractive defects** of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
38. **Cosmetic surgery**, or similar procedures to improve or alter appearance. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a Newborn child, or for Medically Necessary Reconstructive Surgery performed on one breast or both breasts following a mastectomy, as determined by the treating physician, to reestablish symmetry between the two breasts or alleviate functional impairment caused by the mastectomy.
39. **Aids or devices that assist with nonverbal communication**, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, personal digital assistants (PDAs), braille typewriters, visual alert systems for the deaf and memory books except as specifically stated in this Policy.
40. **Non-medical counseling or ancillary services**, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities and developmental delays, except as otherwise stated in this Policy.
41. **Services and procedures for** redundant skin surgery including abdominoplasty/panniculectomy,

removal of skin tags, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; varicose veins; rhinoplasty; blepharoplasty, and; orthognathic surgeries **regardless of clinical indications.**

42. Procedures, surgery or treatments to **change characteristics of the body** to those of the opposite sex unless coverage for such services are deemed to be required by law.
43. Any treatment, Prescription Drug, service or supply **to treat sexual dysfunction**, enhance sexual performance or increase sexual desire.
44. **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
45. Fees associated with the **collection or donation of blood or blood products**, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
46. Blood or blood product administration **for the purpose of general improvement in physical condition.**
47. **Orthopedic shoes** (except when joined to Braces), shoe inserts, foot Orthotic Devices. This exclusion shall not apply to coverage for orthotics or orthoses prescribed by a health care professional to treat insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes.
48. **External and internal power enhancements** or power controls for Prosthetic limbs and terminal devices.
49. **Myoelectric Prostheses** peripheral nerve stimulators.
50. **Electronic Prosthetic limbs or appliances** unless Medically Necessary, when a less-costly alternative is not sufficient.
51. Prefabricated foot Orthoses**.** This exclusion shall not apply to coverage for orthotics or orthoses prescribed by a health care professional to treat insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes.
52. **Cranial banding/cranial Orthoses/other similar devices**, except when used postoperatively for synostotic plagiocephaly.
53. **Orthosis shoes**, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers. This exclusion shall not apply to coverage for orthotics or orthoses prescribed by a health care professional to treat insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes.
54. Orthoses primarily used for cosmetic rather than functional reasons.
55. **Non-foot Orthoses**, except **only** the following non-foot Orthoses are covered when Medically Necessary:
    a. Rigid and semi-rigid custom fabricated Orthoses;
    b. Semi-rigid prefabricated and flexible Orthoses; and
    c. Rigid prefabricated Orthoses, including preparation, fitting and basic additions, such as bars and joints.
56. Services primarily for **weight reduction or for the medical or surgical treatment of obesity including morbid obesity**, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Insured Person has other health

conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction, including drugs whether being used off-label or FDA approved to treat obesity.

57. **Routine physical exams or tests** that do not directly treat an actual Illness, Injury or condition. This includes reports, evaluations, or hospitalization not required for health reasons; physical exams required for or by an employer or for school, or sports physicals, or for insurance or government authority, and court ordered, forensic, or custodial evaluations, except as otherwise specifically stated in this Policy. This exclusion does not apply to Physical Exams which are indicated Preventive Services.
58. Therapy or treatment **intended primarily to improve or maintain general physical condition** or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
59. **Educational services** except for Diabetic Self-Management Training Programs, treatment for Autism, or as specifically provided or arranged by Us.
60. **Nutritional counseling or food supplements**, except as stated in this Policy.
61. **Exercise equipment, comfort items and other medical supplies and equipment** not specifically listed as Covered Services in the "Comprehensive Benefits: What the Policy Pays For" section of this Policy. Excluded medical equipment includes, but is not limited to: air purifiers, air conditioners, humidifiers; treadmills; spas; elevators; supplies for comfort, hygiene or beautification; wigs, disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this Policy.
    a. **Certain Consumable Medical Supplies**, including any item that is for comfort or convenience and
    b. Is not primarily medical in nature. Such items not covered include, but are not limited to: ear plugs; ice packs; silverware/utensils; feeding chairs; and toilet seats;
    c. Has features which are medical in nature but which are not required by the patient's condition; and
    d. Is one for which the FDA does not require a prescription from an eligible provider in order to dispense and is generally available without a prescription.

    ▪

    Some examples of not covered consumable medical supplies are: incontinence pads; lamb's wool pads; face masks (surgical); disposable gloves, sheets and bags, bandages intended for single use, antiseptics, skin preparations, infant formulas or other non-prescription medical foods or enteric formulas.
62. **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the benefit schedule and under "Rehabilitative Therapy Services (Physical Therapy, Occupational Therapy and Speech Therapy)" in the section of this Policy titled "Comprehensive Benefits: What the Policy Pays For."
63. **Foreign Country Provider** charges except as specifically stated under "Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits: What the Policy Pays For."

64. **Routine foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, a systemic condition, Injury or symptoms involving the feet except as otherwise stated in this Policy.
65. **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
66. Charges for the **services of a standby Physician**.
67. Charges for **animal to human organ transplants**.
68. Charges for non-surgical treatment of **Temporomandibular Joint Dysfunction (TMJ).**

Guaranteed Renewable/Premium Subject to Change: This Policy may be subject to non-renewal for Dependents who surpass the maximum Dependent age limit. Otherwise, Your Oscar Plan is guaranteed renewable to at least age 65 upon monthly payment of the required Premium. This Policy will remain in effect continually until terminated by You or by Us per the terms of the TERMINATION section and, subject to Our right to terminate coverage and any amendments permitted under applicable law. We'll never base non-renewal on the deterioration of Your mental or physical health. Please refer to the WHO GETS BENEFITS section of this contract for more information. Your Premium might be increased upon the Renewal Date of this Plan. In the event of a rate increase, We will provide written notice of the increase at least 60 days before the increase takes effect. Rate increases will only take affect after the Pennsylvania Department of Insurance has approved the change, and will apply only at the beginning of a new Plan Year