bright HEALTH℠

2019
Certificate of Coverage

BrightHealthPlan.com

Section 1 - Schedule of Benefits
Silver Perks Plan
(Who Pays What)

Plan Effective Date: January 1, 2019

This Schedule of Benefits does not explain all benefits in detail. For a complete explanation of Your benefits, You should read Your entire Policy.

THIS IS A NETWORK-ONLY PLAN
This plan uses an Exclusive Provider Organization (EPO) to provide benefits to You. That means this Plan does not provide benefits for services You receive from Non-Network Providers, unless:
• You have a medical emergency; or
• Medically Necessary services that You need are not available from a Network Provider.

You can review our provider network online at www.brighthealthplan.com, or You can contact Bright Health Plan Customer Service at (855) 827-4448.

Deductible
A Deductible is the amount that a Covered Person must pay before Bright Health pays any benefits for Covered Health Services. The Deductible amount does not include Coinsurance, Copayment, or non-covered charges.

Copayment
A Copayment is a specific dollar amount that You must pay for certain Covered Health Services.

Coinsurance
A Coinsurance is a percentage of charges for Covered Health Services that must be paid by a Covered Person. Coinsurance amounts do not include Deductible, Copayment, or charges for non-covered services.

Maximum Out-of-Pocket
The Maximum Out-of-Pocket is the maximum dollar amount that a Covered Person may pay in combined Deductible, Copayment and Coinsurance amounts per Calendar Year. All Deductible, Copayment and Coinsurance payments for In-Network Covered Health Services will apply to the Maximum Out-of-Pocket amount. Once the Maximum Out-of-Pocket amount has been met for a Covered Person, the Covered Person will have no further obligation to pay Deductible, Copayment or Coinsurance amounts for Covered Health Services received from a participating Bright Health Provider for the remainder of the Calendar Year. Payments to Non-Network Providers for charges that exceed Usual and Customary reimbursement do not apply to the Maximum Out-of-Pocket.

For policies with two or more people, each person's Individual Out-of-Pocket maximum applies to the Family Maximum Out-of-Pocket. Once a Covered Person has met his or her Maximum Out-of-Pocket, covered In-Network services will be paid at 100% for that person . Once two (2) or more people's combined Out-of-Pocket expenses reach the Family Maximum Out-of-Pocket, covered In-Network services for the family will be paid at 100%.

Limitations/Exclusions
Some limitations and exclusions are listed in this Schedule of Benefits. Refer to Section 8 - Limitations/Exclusions (What is Not Covered) for a more comprehensive listing and description of services or items that are limited or not covered by the Plan.

Deductible		Maximum Out-of-Pocket	
Individual	$3,200	Individual	$7,900
Family	$6,400	Family	$15,800

Allergy Services
Allergy testing and services must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Physician Services		$75 copay/visit	Not covered
Allergy Testing		30% after deductible	Not covered
Allergy Serum		30% after deductible	Not covered

Ambulatory Services - Outpatient Surgery
Outpatient Ambulatory Services must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Outpatient Ambulatory Surgery	Services require pre-authorization.	30% after deductible	Not covered
Surgeon Fees	Services require pre-authorization.	30% after deductible	Not covered

Autism Spectrum Disorder Services
Services for the treatment of Autism Spectrum Disorder must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Habilitative and Rehabilitative Outpatient Therapy Services (Speech, Occupational or Physical Therapy)	Services require pre-authorization.	30% after deductible	Not covered
Autism - Applied Behavioral Analysis	Services require pre-authorization.	30% after deductible	Not covered

Bariatric Surgery

Bariatric Surgery must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Bariatric Surgery	Services require pre-authorization.	30% after deductible	Not covered
Surgeon Fees	Services require pre-authorization.	30% after deductible	Not covered

Chemotherapy and Radiation Treatment

Chemotherapy and Radiation treatment must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Chemotherapy or Radiation Treatment	Services require pre-authorization.	30% after deductible	Not covered

Chiropractic Care

Chiropractic Care must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Spinal Manipulations	Limited to 20 visits per year	30% after deductible	Not covered
Diagnostic X-ray Services		30% after deductible	Not covered

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Clinical Trials

Services related to a Clinical Trial must be provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice. The facility and personnel providing the clinical trial treatment must have the experience and training to provide the treatment in a competent manner. Services apply a cost-share amount based on the type of physician or facility providing care.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*		*NON-NETWORK*
Primary Care Services	Services require pre-authorization.	$30 copay/visit		Not covered
Specialty Care Services	Services require pre-authorization.	$75 copay/visit		Not covered
Hospital Services	Services require pre-authorization.	30% after deductible		Not covered
Laboratory & Radiology Services	Services require pre-authorization.	30% after deductible		Not covered
Prescription Drugs	Retail prescriptions include up to a 30-day supply of medications. Mail Order prescriptions include up to a 90-day supply of medications.	*RETAIL IN-NETWORK*	*MAIL ORDER IN-NETWORK*	*NON-NETWORK*
Preventive Medications (Tier 1)		No charge	No charge	Not covered
Generic (Tier 2)		$15 / prescription	$37.50 / prescription	Not covered
Preferred Brand (Tier 3)		$80 / prescription	$200 / precription	Not covered
Non-Preferred Brand (Tier 4)		$180 / prescription	$450 / precription	Not covered
Specialty Medications (Tier 5)		$650 / prescription	$650 / prescription	Not covered

Diabetic Shoes

Custom shoes for diabetics must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Custom Shoes for Diabetics	Services require pre-authorization.	30% after deductible	Not covered

Dialysis Services

Dialysis treatment must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Dialysis Treatment	Services require pre-authorization.	30% after deductible	Not covered

Durable Medical Equipment

Durable Medical Equipment and Devices must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Durable Medical Equipment and Devices	Services require pre-authorization.	30% after deductible	Not covered

Early Intervention Services

Early Intervention Services received from a Non-Network Providers will be paid at the In-Network benefit level. Payment to the Non-Network Provider will be based on reimbursement levels paid to Participating Providers. Non-Network Providers may bill you for charges that exceed the In-Network reimbursement level. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Early Intervention Services	Limited to 45 visits per year	Covered at 100% of Allowable Amount	Not covered

Emergency Health Services and Urgent Care Services

Emergency and Urgent Care Services received from Non-Network Providers will be covered at the In-Network benefit level. Payment to the Non-Network Provider will be based on Our Allowable Charge. Non-Network Providers may bill you for charges that exceed Bright Health's allowed charges.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Emergency Room Services (Facility charges)		30% after deductible	30% after deductible
Emergency Room Services (Ancillary charges)		30% after deductible	30% after deductible
Emergency Ambulance Transport (Ground/Air)		30% after deductible	30% after deductible
Urgent Care Center Services (Facility charges)		$75 copay/visit	$75 copay/visit
Urgent Care Center Services (Ancillary charges)		30% after deductible	30% after deductible

Genetic Testing and Counseling

Genetic Testing and Counseling Services must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Genetic Testing & Counseling	Services require pre-authorization.	30% after deductible	Not covered

Hearing Services

Hearing Services must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Hearing Exam and Testing	Limited to 1 screening per year to detect the need for hearing correction.	30% after deductible	Not covered
Hearing Aids for Children	Limited to children under age 18; Plan will cover the initial hearing aids and replacement hearing aids every five (5) years, or when the existing hearing aid no longer adequately meets the needs of the child.	30% after deductible	Not covered

Home Health Care

Home Health Care Services must be received from a Participating Bright Health Plan provider. Services received from Non-

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Home Health Services	Limited to 28 hours per week. Services require pre-authorization.	30% after deductible	Not covered

Hospice Care Services

Hospice Care must be received from a Participating Bright Health Plan hospice facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Hospice Care	Services require pre-authorization.	30% after deductible	Not covered
Bereavement Support Services	See Outpatient Mental Health & Substance Abuse Services	$75 copay/visit	Not covered

Hospital Services

Services must be received from a Participating Bright Health Plan hospital facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Inpatient Hospital Services	Services require pre-authorization.	30% after deductible	Not covered
Inpatient Rehabilitation Facility Services	Services require pre-authorization.	30% after deductible	Not covered
Surgeon Fees	Services require pre-authorization.	30% after deductible	Not covered
Skilled Nursing Facility	Limited to 100 days per year; Services require pre-authorization.	30% after deductible	Not covered

Infertility Services

Infertility Services must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Diagnosis and Management	Coverage includes services for diagnosis and treatment of involuntary infertility. Services require pre-authorization.	30% after deductible	Not covered
Treatment for Infertility	Services to reverse voluntary sterilization or infertility are not covered. Services require pre-authorization.	30% after deductible	Not covered
Artificial Insemination	Services require pre-authorization. Artificial Insemination is covered except for donor semen, donor eggs and services related to their procurement and storage.	30% after deductible	Not covered

Infusion Therapy

Infusion Therapy Services must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Infusion Therapy	Services require pre-authorization.	30% after deductible	Not covered

Lab, X-Ray and Diagnostic Services

Diagnostic services must be received from a Participating Bright Health Plan provider, hospital or outpatient facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Diagnostic Outpatient Laboratory & Radiology & Testing		30% after deductible	Not covered
High-tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	Services require pre-authorization.	30% after deductible	Not covered

Mental Health and Substance Abuse Services

Mental Health and Substance Abuse services must be received from a Participating Bright Health Plan provider or facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Inpatient Mental Health Care	Services require pre-authorization.	30% after deductible	Not covered
Outpatient Mental Health Office Visit	For diagnostic lab or x-ray services, deductible and coinsurance apply. Hospital-owned clinics may charge a "clinic fee". These charges will apply deductible and coinsurance.	$75 copay/visit	Not covered
Inpatient Substance Abuse Services	Services require pre-authorization.	30% after deductible	Not covered
Outpatient Substance Abuse Office Visits	For diagnostic lab or x-ray services, deductible and coinsurance apply. Hospital-owned clinics may charge a "clinic fee". These charges will apply deductible and coinsurance.	$75 copay/visit	Not covered
Outpatient Electroconvulsive Therapy (ECT)	Services require pre-authorization.	$75 copay/visit	Not covered

Pediatric Dental Services

Pediatric Dental Services are available for dependent children under 19 years of age. Services must be received from a Participating Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Oral Exams	Limited to 2 visits per year	No charge	Not covered
X-rays (bitewings)	Limited to 1 set per year		
X-rays (Full mouth/panoramic)	Limited to 1 set every 60 months		
X-rays (intra-oral)	Limited to 2 sets per year		
Routine Cleanings	Limited to 2 per year		
Fluoride Treatments	Limited to 2 applications per year		
Space Maintainers	Limited to 1 per lifetime		
Sealants	Limited to 1 per tooth per year		
Palliative Treatment	Limited to 1 treatment per year		
Fillings (amalgam, resin and composite or sedative)	Limited to 2 fillings per year		
Crowns	Limited to 1 crown per year		
Pin retention	Limited to 1 retention per year		
Surgical extractions	Limited to 2 extractions per year		
Endodontics, including surgical services and root canal therapy	Limited to 2 root canals per year		
Medically necessary orthodontia and prosthodontics for the treatment of cleft lip and cleft palate	Services require pre-authorization.	30% after deductible	Not covered

Pediatric Vision Services

Pediatric Vision Services are available for dependent children under 19 years of age. Services and must be received from a Participating Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Pediatric Routine Eye Exam	Limited to 1 refractive eye exam per year to determine the need for vision correction.	No charge	Not covered
Eyeglasses for Children	Limited to 1 pair of eyeglasses every 24 months, including frames and lenses. Contact lenses are limited to a one year supply.	No charge up to the Provider's contracted amount.	Not covered

Pharmaceutical Products and Medical Supplies
Pharmaceutical Products and Medical Supplies are covered when provided by a Participating Provider. Services for Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Physician Administered Medications	Services require pre-authorization.	30% after deductible	Not covered
Prescribed Medical Supplies	Limited to the use of Durable Medical Equipment or in a Home Healthcare setting.	30% after deductible	Not covered
Ostomy Supplies	Deodorants and lubricants are not covered.	30% after deductible	Not covered

Physician's Office Services
Physician services must be received from a Participating Bright Health Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Primary Care Office Visits	For diagnostic lab or x-ray services, deductible and coinsurance apply. Hospital-owned clinics may charge a "clinic fee". These charges will apply deductible and coinsurance.	$30 copay/visit	Not covered
Specialist Office Visits	For diagnostic lab or x-ray services, deductible and coinsurance apply. Hospital-owned clinics may charge a "clinic fee". These charges will apply deductible and coinsurance.	$75 copay/visit	Not covered
Clinic Fees for Office Visits at an Outpatient Clinic (hospital-owned clinic)		30% after deductible	Not covered

Pregnancy - Maternity Services

Maternity services must be received from a Participating Bright Health Plan provider or facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Inpatient Hospital Delivery and Birthing Center, including Prenatal and Postnatal Care and Midwife Services	Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean require pre-authorization. Services for newborn care after the mother's hospital discharge require pre-authorization.	30% after deductible	Not covered

Prescription Drugs

Prescription Drugs must be received from a Participating Bright Health Pharmacy. Services received from a Non-Network Pharmacy will not be covered. To find a Participating Pharmacy, please visit our website at www.brighthealthplan.com, or call our Customer Service at (855) 827-4448.

SERVICE	*PLAN LIMITATIONS*	*RETAIL IN-NETWORK*	*MAIL ORDER IN-NETWORK*	*NON-NETWORK*
Preventive Medications and Formulary Contraceptive Medications and Devices (Tier 1)	Retail prescriptions include up to a 30-day supply of medications. Mail Order prescriptions include up to a 90-day supply of medications.	No Charge	No Charge	Not covered
Generic (Tier 2)		$15 / prescription	$37.50 / prescription	
Preferred Brand (Tier 3)		$80 / prescription	$200 / precription	
Non-Preferred Brand (Tier 4)		$180 / prescription	$450 / precription	
Specialty Medications (Tier 5)		$650 / prescription	$650 / prescription	

Preventive and Wellness Services

Preventive Care Services received from a Participating Bright Health Provider are covered at No Charge for You. Services received from Non-Network Providers will not be covered. Please refer to the What Is Covered section of Your Policy for a list of covered Preventive Health Services. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Wellness Exams (Adult & Child)	Covered Health Services under this section include preventive health care services in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, preventive services mandated by Colorado statute, women's preventive service guidelines published by the Health Resources and Services Administration in the U.S. Department of Health and Human Services and the Advisory Committee on Immunization Practices. Refer to your Certificate of Coverage for a list of covered services and applicable limitations.	No charge	Not covered
Immunizations		No charge	
Colorectal Cancer Screening		No charge	
Breast Cancer Screening		No charge	

Prosthetics

Prosthetic Devices must be received from a Participating Bright Health Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Prosthetic Limbs	Services require pre-authorization.	30% after deductible	Not covered
Internally Implanted Prosthetic Devices	Services require pre-authorization.	30% after deductible	Not covered
All Other Prosthetic Devices	Services require pre-authorization.	30% after deductible	Not covered

Rehabilitative and Habilitative Services

Rehabilitative and Habilitative Services must be received from a Participating Bright Health Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Speech Therapy	Limited to 20 visits per therapy type per year for rehabilitative services, and 20 visits per therapy type per year for habilitative services. Not limited for children up to age 5 with congenital defects. No therapy limitation for autism.	30% after deductible	Not covered
Occupational Therapy		30% after deductible	Not covered
Physical Therapy		30% after deductible	Not covered
Inpatient Habilitation/Rehabilitation	Limited to 2 months per calendar year. Services require pre-authorization.	30% after deductible	Not covered

Sleep Studies

Sleep Studies must be received from a Participating Bright Health Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Sleep Studies	Services require pre-authorization.	30% after deductible	Not covered

Temporomandibular Joint Disorder Treatment

Services for the treatment of Temporomandibular Joint Disorder must be received from a Participating Bright Health Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Services for the treatment of Temporomandibular Joint Disorder	Services require pre-authorization.	30% after deductible	Not covered

Transplantation Services

Transplantation Services must be received from a Participating Bright Health Center of Excellence. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 827-4448 to locate a Participating Provider or Facility.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Organ and Tissue Transplants	Services require pre-authorization.	30% after deductible	Not covered

Travel Expenses

Pre-arranged travel expenses, including meals and lodging when it is medically necessary, as determined by Us, for a Covered Person to receive care from a designated facility that is located more than 100 miles from the Covered Person's home are reimbursable by the Plan. Care must be directed by the Plan.

SERVICE	*PLAN LIMITATIONS*	*YOUR COST*
Travel Expenses (Lodging and Food)	Plan will reimburse up to Federal CONUS rate for lodging and food for the city in which services are received.	No charge
Mileage for use of a motor vehicle	Plan will reimburse in accordance with the current IRS allowance per mile for medical travel.	No charge
Airfare	Plan reimbursement is limited to the cost of a round-trip coach airfare to the facility, unless medically necessary to travel in a different capacity.	No charge

Wigs

SERVICE	*PLAN LIMITATIONS*	*YOUR COST*
Wigs	Limited to 1 wig per year, up to $500.	No charge

Section 2 - Title Page (Cover Page)
Individual Policy

Plan Name: Bright Health Insurance Company Silver Perks		
Member Name: [ ]	**Coverage Effective Date: [ ]**	**Premium Amount: [ ]**

This document includes important information that describes Your Policy. Your Policy is a legal contract between the Subscriber and Bright Health Insurance Company, hereinafter referred to as "Bright Health". It explains the Benefits for health care services. Benefits are for Covered Persons and are subject to plan terms, conditions, exclusions and limitations. This Policy is issued when We receive the application and in consideration of any and all required payment(s).

Entire Contract

This Policy includes Your:

- Schedule of Benefits
- enrollment application

The documents above make up the entire contract between Bright Health and the Subscriber.

As of the effective date of the Contract, this Policy supersedes all other agreements between the Subscriber and Bright Health. Changes to the Policy must be given to You in writing. Changes to the Policy must be signed by the executive officer of Bright Health and approval must be endorsed on or attached to this Policy. No agent has authority to change this policy or to waive any of its provisions.

How to Use this Document

Read Your Policy and Amendments. We especially encourage You to review these sections:

- Schedule of Benefits
- What is Covered
- Limitations/Exclusions

Make sure You understand how Your Policy works. Many sections refer to other sections. You may not find all the information You need in one section. Keep the Policy in a safe place so you can find and read it as needed.

Information about Defined Terms

The Definitions section of this Policy will help you understand the content. When you see a word or term that begins with a capital letter, you will find it in the Definitions section. Please read the Definition to find out what a word or term means.

When You see the words "We," "Us," and "Our", We are referring to Bright Health. When You see the words "You" and "Your," We are referring to Covered Persons. If the Covered Person is under age 18, "You" and "Your" refers to the Responsible Adult.

BRIGHT HEALTH

Jon Watson
Chief Executive Officer

Section 3 - Contact Us

Please contact Us for more information.

Questions About Your Benefits

Customer Service:
(855) 827-4448
TTY: 711

On Our Website at:
www.brighthealthplan.com

To Send Us Claims or Other Written Correspondence, Mail to:
Claim Submissions and Correspondence Address:

Bright Health Plan
P.O. Box 16275
Reading, PA 19612

Language Assistance Services
If You or someone you're helping has questions about Bright Health, You have the right to get help and information in Your language, at no cost. To talk to an interpreter, call (855) 827-4448.

Spanish
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Bright Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (855) 827-4448.

Vietnamese
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Bright Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (855) 827-4448.

Chinese
如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Bright Health方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 (855) 827-4448。

Korean
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Bright Health에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 (855) 827-4448로 전화하십시오.

Russian
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Bright Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (855) 827-4448.

Amharic
እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Bright Health ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ (855) 827-4448 ይደውሉ።

Arabic
فلديك الحق في الحصول على المساعدة والمعلومات، Bright Health إن كان لديك أو لدى شخص تساعده أسئلة بخصوص الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب)855 (827-4448.

German
Falls Sie oder jemand, dem Sie helfen, Fragen zum Bright Health haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (855) 827-4448 an.

French
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Bright Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (855) 827-4448.

Nepali
यदि तपाईं आफ्ना लादि आफैं आवेिनको काम िि◌ै, वा कसैलाई मद्दत िि◌ै हुनुहुन्छ, Bright Health बारे प्रश्नहरू छन् भने आफ्नो मातृभाषामा दन:शुल्क सहायता वा जानकारी पाउने अदिकार छ । ि◌ोभाषे (इन्टरप्रेटर) सँि◌ कुरा ि◌नु◌ुपरे (855) 827-4448 मा फोन ि◌नु◌ुहोस् ।

Tagalog
Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Bright Health, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa (855) 827-4448.

Japanese
ご本人様、またはお客様の身の回りの方でも、Bright Healthについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(855) 827-4448までお電話ください。

Cushite-Oromo
Isin yookan namni biraa isin deeggartan Bright Health irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa (855) 827-4448 tiin bilbilaa.

Persian
داشته باشید حق این را دارید که کمک ، Bright Health اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد
. و اطلاعات به زبان خود را به طور رایگان دریافت نمایید 827-4448 (855 .)تماس حاصل نمایید

Kru
I bale we, tole mut u ye hola, a gwee mbarga inyu Bright Health, U gwee Kunde I kosna mahola ni biniiguene I hop wong nni nsaa wogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel (855) 827-4448.

Ibo
Ọ bụrụ gị, ma o bụ onye I na eyere-aka, nwere ajụjụ gbasara Bright Health, I nwere ohere iwenta nye maka na ọmụma na asụsụ gị na akwu gị ụgwọ. I chọrọ I kwụrụ onye-ntapịa okwu, kpọ (855) 827-4448.

Yoruba
Bí ìwọ, tàbí ẹnikẹni tí o n ranlọwọ, bá ní ibeere nípa Bright Health, o ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ongbufọ kan sọrọ, pè sórí (855) 827-4448.

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Section 5 - Eligibility

We offer two types of Individual policies:

1. Individual Policies: these policies include coverage for at least one adult age 19 or older, and also includes coverage for eligible Dependents.
2. Individual Child-Only Policies: these policies include coverage for children under age 21, without a parent or legal guardian enrolling in the Plan.

Except as stated above, criteria for eligibility is the same for both types of plans. When an Eligible Individual is enrolled, We refer to that person as a Covered Person, You or Your.

Who is Eligible for Coverage

Eligible Subscribers

To be eligible to enroll as a Subscriber under this Plan, You must

- Reside in the Service Area (if You or an enrolled Dependent reside outside of the Service Area and incur health care services, You may be subject to higher Out-of-Pocket expenses);
- Not be enrolled in Medicare on Your effective date of coverage with Us. It is unlawful for Us to knowingly issue an individual market policy to You if You are enrolled in Medicare on Your effective date. If we have knowledge of Your enrollment in Medicare, we will not issue a Policy to You.

Eligible Dependents

The following persons may be eligible to enroll as Dependents under this plan:

- A Spouse as defined in the *Definitions section of this Policy, except in the case of a child-only Policy*.
- Your Child(ren) as defined in the *Definitions section of this Policy*.

When a Dependent is actually enrolled, We refer to that person as an Enrolled Dependent or Enrolled Child, as appropriate.

For a complete definition of Dependent, Child(ren), and Enrolled Dependent, see the *Definitions section of this Policy*.

When Coverage Begins

If you are a new enrollee with Bright Health and have paid your first month's premium, your coverage will begin on the date listed as the Effective Date on Your ID Card. No health services received prior to the Effective Date are covered.

Policies for new enrollees begin on the first of the month only.

If you are a new or renewing enrollee with Bright Health and You had coverage with Us in the past 12 months, Your premiums from the last 12 months must be paid in full before Your Policy will renew. If You have an outstanding premium balance, payment made for Your new or renewing Policy will be applied to Your outstanding premium amount owed to Us before being applied to Your new or renewing Policy. Premiums for the prior 12 months must be current, and the first month's premium for Your new or renewing Policy must be paid before Your policy becomes effective.

Enrolling Eligible Dependents

Dependents who have a Qualifying Life Event as defined by state and federal law may be enrolled during the special enrollment period as described below. The special enrollment period is a period in which enrollment is allowed before or after an individual becomes eligible for coverage due to any of the Qualifying Life Events listed below.

Dependents who are notified or become aware of the Qualifying Life Event may enroll during the sixty (60) calendar days before or after the effective date of the Qualifying Life Event, with coverage beginning no earlier than the day the Qualifying Life Event occurs. Qualifying Life Events include:

- An individual involuntarily loses existing creditable coverage for any reason other than fraud, misrepresentation, or failure to pay a premium;
- An individual gains a Dependent or becomes a Dependent through marriage, civil union, birth, adoption, or placement for adoption, placement for foster care, or by entering into a Designated Beneficiary agreement;
- An individual's enrollment or nonenrollment in a health benefit plan is unintentional, inadvertent, or erroneous and is the result of an error, misrepresentation, or inaction of the carrier, producer, or Exchange;
- An individual adequately demonstrates to the commissioner that the health benefit plan in which the individual is enrolled has substantially violated a material provision of its contract in relation to the individual;
- The Exchange determines an individual to be newly eligible or newly ineligible for the federal advance payment tax credit or cost-sharing reductions available through the Exchange pursuant to federal law;
- An individual gains access to other creditable coverage as a result of a permanent change of residence; or
- A parent or legal guardian dis-enrolling a Dependent, or a Dependent becoming ineligible for the Children's Basic Health Plan;
- An individual becoming ineligible under the Colorado Medical Assistance Act;
- An individual, who was not previously a citizen, a national, or a lawfully present individual, gains such status; or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month.
- Any other event or circumstance occurs as set forth in rules from the Colorado Division of Insurance that defines triggering events.

If You become aware of a qualifying event that will occur in the future, You may apply for coverage during the sixty (60) calendar days prior to the effective date of the qualifying event.

If the Dependent had coverage with Us in the past 12 months, and has an outstanding premium amount, payment made for the Special Enrollment Period will be applied to the outstanding premium amount. Premiums for the prior coverage must be current, and the first month's premium for the Special Enrollment Period must be paid before the Dependent's Policy becomes effective.

A newborn child is automatically covered for the first 31 days of life, including dependents of dependents. If you wish to continue enrollment of the newborn beyond the 31st day, the newborn must meet the definition of an eligible Child, and you must enroll the newborn within 60 days of the date of birth. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber is required to pay the full premium amount for the newborn after the initial 31 days of coverage.

Newly adopted children (including children newly placed for adoption), the effective date of coverage is the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 60 days from the date the child is placed in Your custody or the date of the final decree of adoption. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber is required to pay the full premium amount for the adopted child. The monthly premium for the newly adopted child is the entire month's premium. Adopted child premiums are not pro-rated.

For all other Dependents, if enrolled within 60 days of becoming eligible, the effective date of coverage will be the first day of the month following the date We receive the enrollment application and any written documentation that may be required to support the effective date of the qualifying event, and any required Premium. Proof of the qualifying event, i.e. a copy of the marriage certificate, Qualified Medical Support Order, etc. must be attached to the completed application.

Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to enroll unless they enroll under the provisions described in the special enrollment period section described above.

If You Are Hospitalized When Your Coverage Begins

If You are inpatient in a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility on the day Your coverage begins and You were insured through a carrier other than Bright Health on the date you were admitted, Your prior carrier is responsible for payment of Covered Health Services for the Inpatient Stay through the date of discharge. Bright Health will pay for related Covered Health Services in accordance with the terms of the Policy, following discharge from the hospitalization. We will work with You to ensure a seamless transition of previously approved therapies or prescription medications.

You should notify Us of Your Hospitalization within 24 hours of the day Your coverage begins, or as soon as it is reasonably possible. For Benefit plans that have a Network Benefit level, Network Coverage is available only if You receive Covered Health Services from Network Providers.

Section 6 - How to Access Your Services and Obtain Approval of Benefits

Covered Health Services

Benefits under this plan are limited to those Covered Health Services included in the *Benefits/Coverages (What is Covered) section of this* document. Benefits are reimbursable as set forth in the *Schedule of Benefits*. All Covered Health Services are subject to the limitations and exclusions contained in the *Limitations/Exclusions (What is Not Covered) Section of this Policy*.

THIS IS A NETWORK-ONLY PLAN

This plan uses an Exclusive Provider Organization (EPO) to provide benefits to You. That means this Plan does not provide benefits for services You receive from Non-Network Providers, unless:

- You have a medical emergency; or
- Medically Necessary services that You need are not available from a Network Provider.

You can review Our provider network online at www.brighthealthplan.com, or You can contact the *Customer Service* Department at the telephone number listed in *Section 3* of this *Policy* and on Your ID card to obtain a copy of Our Provider Directory.

BENEFITS ARE NOT AVAILABLE WHEN YOU USE A NON-NETWORK PROVIDER, EXCEPT FOR EMERGENCY HEALTH SERVICES OR SERVICES RECEIVED FROM AN ANCILLARY PROVIDER AT A NETWORK FACILITY.

Choose Your Physician

It is Your responsibility to select the health care professionals who deliver care to You.

Your choice of Physicians and Hospitals may determine which services will be covered, as well as how much You will pay. Network Providers are listed on Our website at ***www.brighthealthplan.com*** or You can contact the *Customer Service* Department at the telephone number listed in *Section 3* of this *Policy* and on Your ID card to obtain a copy of Our Provider Directory.

Network Providers are subject to a credentialing process, in which either We or Our designees confirm public information about the Network Provider's licensure and other professional credentials. However, the credentialing process does not assure the quality of the Network Provider's services. The Network Providers are independent practitioners and facilities and are solely responsible for the care they deliver.

This plan allows You to:

- Choose Physicians and Hospitals for Your health care needs;
- Have direct access to eye care providers, mental health care providers, pediatricians, obstetrical or gynecological health care professionals. You do not need pre-authorization from the plan or from any other person (including a primary care provider) in order to obtain access to mental health, obstetrical, or gynecological care from a health care professional in Our network who specializes in those types of services. The health care professional, however, may be required to comply with certain provisions related to 1) obtaining Pre-authorization 2) following a pre-approved treatment plan, or 3) following procedures for making referrals to Network Providers. For a list of participating health care professionals who specialize in eye care, mental health, and obstetrics or gynecology, visit Our website at www.brighthealthplan.com or call Our Customer Service line at the number listed in Section 3 of this Policy and on Your ID card. Take advantage of significant cost savings when You use doctors contracted with Us.

Services from Non-Network Providers are not covered except for Emergency Health Services. Non-Network Providers are not contracted with Us. If You access services from a Non-Network

Provider for non-Emergency Health Services, You will be responsible for the entire amount that the Provider bills.

Provider Network

We arrange for health care providers to participate in a Network. Network Providers are independent practitioners. They are not Our employees. It is Your responsibility to select Your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services, You should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Service*. A directory of providers is available online at ***www.brighthealthplan.com*** or You may obtain a copy by calling *Customer Service* at the telephone number listed in Section 3 of this Policy and on Your ID card.

It is possible that You will not be able to obtain services from a particular Network Provider. The network of providers is subject to change. You might find that a particular Network Provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to You, You must choose another Network Provider to get Network Benefits.

Our provider network includes a sufficient number of essential community providers (ECPs) within our geographic service area, where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in health professional shortage areas. Our provider network complies with the Colorado network adequacy standards.

Transition of Care

Transition of Care allows you to continue to receive services for specified medical and behavioral conditions for a defined period of time with doctors, hospitals, and Providers who are Non-Network until the safe transfer of care to a Network Provider can be arranged.

You must apply for Transition of Care at enrollment, or change in your Health plan, but no later than 30 days after the effective date of your coverage.

Examples of acute medical conditions (and/or situations) that may require Transition of Care:

- Pregnancy, in the third trimester of care
- Solid organ transplants on a transplant list and anticipated to undergo transplant within 30 days
- Bone marrow transplants who are less than six months post transplant
- End-stage renal disease and dialysis
- Terminal illness with an anticipated life expectancy of six months or less

Examples of conditions that generally do not warrant Transition of Care:

- Routine exams, vaccinations, and health assessments
- Stable chronic conditions such as diabetes, arthritis, allergies, asthma, glaucoma, etc.
- Elective scheduled surgeries such as removal of lesions, arthroscopies, hernia repairs, hysterectomy, etc.
- Services for speech therapy, physical therapy and home health care.
- Participation in a chronic disease treatment program, for which we have a comparable program.

For information on how to apply for Transition of Care, contact Bright Health Plan Customer Service at (855) 827-4448.

Continuity of Care

Continuity of Care allows you to receive services at Network coverage levels for specified medical and behavioral conditions for a defined period of time when your Network doctor, hospital, or Provider leaves our Network and there are strong clinical reasons preventing immediate transfer of care to another Network Provider. You must apply for Continuity of Care within 30 days of your

Network Provider leaving our Network. Requests will be reviewed within 10 days of receipt; organ transplant requests will take longer.

If you are under the care of a Network Provider for one of the medical conditions below, and the Network Provider caring for you is terminated from the Network by us, we can arrange, at your request and subject to the Provider's agreement, for continuation of Covered Health Services rendered by the terminated Provider for the time periods shown below. Co-payments, Deductibles or other cost sharing components will be the same as you would have paid for a Provider currently contracting with us.

Medical conditions and time periods for which treatment by a terminated Network Provider will be covered under the Policy are:

- An Acute Condition or Serious Chronic Condition. Treatment by the terminated Provider may continue for up to 90 days.
- A high risk Pregnancy or a Pregnancy that has reached the second or third trimester. Treatment by the terminated Provider may continue until the postpartum services related to the delivery are completed.

This section does not apply to treatment by a Provider or Provider group whose contract with us has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract with Us to provide only certain Covered Health Services, but not all Covered Health Services. Refer to Your provider directory or contact Us for assistance.

For information on how to apply for Continuity of Care, contact Bright Health Plan Customer Service at (855) 827-4448.

You can obtain a listing of Network Providers on Our website, or by contacting the Customer Service Department at the telephone number listed in Section 3 of this Policy and on Your ID card. The provider's Network status is subject to change, so always confirm the provider's Network status with the provider at the time services are received.

Access Plan

We have prepared and maintain a Network Access Plan that describes how We monitor the Network of providers to ensure that You have access to care. The Network access plan is maintained at Our offices. Please contact *Customer Service* at the number listed in *Section 3 of this Policy* and on Your ID card for the location office nearest You.

Designated Facilities and Other Providers

If You have a medical condition that We believe needs special services, We may direct You to a Designated Facility or designated Physician chosen by Us. If You require certain complex Covered Health Services for which expertise is limited, We may direct You to a Network facility or provider that is outside Your Service Area. If You are required to travel to obtain such Covered Health Services from a Designated Facility or designated Physician, We may reimburse certain travel expenses at Our discretion.

In both cases, Network Benefits will only be paid if Your Covered Health Services for that condition are provided by or arranged by the Designated Facility, designated Physician, or other provider chosen by Us. The Designated Facility, Physician or other provider chosen by us must abide by the Preauthorization terms of this Policy.

You or Your Network Physician must notify Us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or designated Physician. If You do not notify Us in advance and if You receive services from a Non-Network facility, (regardless of whether it is a Designated Facility) or other Non-Network Provider, Network Benefits will not be paid.

Receiving Care From Non-Network Providers

This plan does not cover non-emergency services rendered by Non-Network Providers. However, emergency medical services or services received from a Non-Network Provider in a Network hospital or facility are covered at the In-Network benefit level.

To ensure that the Providers You are seeing are In-Network, visit our website at www.brighthealthplan, or call Us at (855) 827-4448.

When receiving emergency care from a Non-Network Provider in a Non-Network facility, payment from the Plan will be limited to the Allowable Amount. The Allowable Amount is the amount negotiated by Us with the Non-Network Provider, or up to 160% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, whichever is less.

Non-Network Providers are allowed to bill any amount they wish for health care services. The charges that they bill may be more than Our Allowable Amount. You will be responsible for Your Copayment, Deductible and Coinsurance amounts, and for charges that the Non-Network Provider bills above of the Allowable Amount.

Payment for Charges to Non-Network Providers

If You receive care from a Non-Network Provider, You may be required to pay the charges in full to that Provider at the time of service. To be reimbursed for the charges You have paid, You will need to provide Us with an itemized bill.

Itemized bills must be submitted on billing forms or the Provider's letterhead or stationery and must include:

- The name and address of the Physician or other health care Provider, Tax ID Number and NPI Number;
- The full name, address and date of birth of the patient receiving treatment or services; and
- The date of service, type of service, diagnosis, and charge for each service separately.

Canceled checks, balance due statements, cash register receipts or bills You prepare Yourself are not acceptable. Please make a copy of all itemized bills for Your records before You send them because the bills are not returned to You. Itemized bills are necessary for Your claim to be processed so that all benefits available under Your plan are provided.

Claims for services rendered by a Non-Participating Provider must be submitted to the Plan within one year (365 days) from the date of service. If Your Non-Network Provider does not file a claim for You, You are responsible for filing the claim within the one-year deadline. Claims submitted after the deadline are not eligible for benefit payment or reimbursement. If a claim is returned to You because We need additional information, You must resubmit it, with the information requested, within 90 days of the request.

Limitations on Selection of Providers

If We determine that You are using health care services in a harmful or abusive manner, or with harmful frequency, Your selection of Network Providers may be limited. If this happens, We may require You to select a single Network Physician to provide and coordinate all future Covered Health Services. If You don't make a selection within 31 days of the date We notify You, We will select a single Network Physician for You. If You fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Service Area

Your Service Area is an area (based on full or partial counties) where Network Covered Health Services are generally available and readily accessible to You and Your covered Dependents.

Your Service Area includes the following counties: Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, and Summit counties.

Services from Network Providers can be accessed anywhere in Your Service Area. Any services received outside of Your Service Area from a Non-Network Provider will be considered Non-Network, with the exception of Emergency Health Services, and will not be covered. Emergency Health Services will be covered as Network Benefits regardless of the provider's Network status or Service Area.

Nonemergency health services received from Non-Network Providers or received outside of Your Service Area will not be covered.

Please see Our provider directory on Our website at ***www.brighthealthplan.com*** for a list of Network Providers in the Service Area or contact the *Customer Service* Department at the telephone number listed in Section 3 of this Policy and on Your ID card for assistance.

Medical Necessity

Understanding Medical Necessity is important for You as a Member because the decisions about coverage and treatment affect You. You need this information to make prudent choices.

We define a service, procedure or intervention as Medically Necessary if it meets all of the following criteria:

- it is a health intervention for the purpose of treating a medical condition
- it is the most appropriate supply or level of service, considering potential benefits and harms to the patient
- it is known to be effective in improving health outcomes.

We use the following types of information in making decisions about medical necessity:

- For new interventions, effectiveness is determined by scientific evidence.
- For existing interventions, effectiveness is determined
  1. by scientific evidence
  2. by professional standards
  3. by expert opinion; and
  4. by consideration of cost-effectiveness compared to alternative interventions, including no intervention.

Second Opinions

Second opinions should be received from an In-Network provider, when available. If You receive a second opinion from a Non-Network Provider when services could have been rendered In-Network, You may be required to pay those charges in full. We provide a network of Providers that meet all applicable network adequacy requirements. However, if We determine that a gap exists in our network, We may approve treatment with an otherwise Non-Network Provider on a case-by-case basis and limited in scope in accordance with Our network exceptions policy.

Pre-authorization

Pre-authorization is the process of reviewing a request for health care services for Medical Necessity and network affiliation prior to You receiving those services.

Who is responsible for obtaining Pre-authorization?

If You are receiving care from a Network Provider, the Network Provider is responsible for obtaining Pre-authorization before they provide these services to You. If the Provider fails to obtain Pre-authorization and the service is denied, he or she may not balance bill You.

If You are receiving care outside of Your Service Area, or care from a Non-Network Provider, You are responsible for making sure that Pre-authorization is obtained. Information regarding services can come from the Non-Network Provider or from You.

Through the Pre-authorization process, You may qualify for specialty programs, which include but are not limited to:

- the provision of informed decision making materials;

- the provision of information on how to choose higher quality, lower cost centers, or providers; access to special care Success programs; and
- the assignment of a case or disease management professional to assist You in evaluating and understanding health care choices.

Failure to obtain the Pre-authorization prior to receiving care may result in services not being covered, regardless of the circumstances or Medical Necessity.

Pre-authorization is required for the following services:

- Acute Rehabilitation services
- Applied Behavioral Analysis
- Autism/Autism Spectrum Disorder Treatment
- Bariatric Surgery
- Behavioral Health/Substance Abuse (Mental/Nervous/Chemical/Alcohol Dependency)
  - Inpatient Facility
  - Inpatient Rehabilitation
  - Partial Hospitalization
  - Intensive Outpatient Treatment
  - Outpatient Detoxification
- Chemotherapy
- Clinical Trials
- Colonoscopy, including monitored anesthesia for deep sedation for Colonoscopy
- Custom Shoes for Diabetics
- Dialysis, Hemodialysis and Peritoneal Dialysis
- Durable Medical Equipment
- Enteral Nutrition
- Gender Identity & Gender Transition Services
- Genetic testing and counseling
- Hearing Aids
- Home Health Care
- Home Infusion Therapy
- Hospice
- Hospital admission (Inpatient or Observation). If You are admitted for an emergent inpatient medical or surgical hospitalization, You or Your provider must notify Us within 23 hours of the admission, or as soon as reasonably possible. If Your hospitalization is non-urgent, Your provider must request Pre-authorization at least 5 business days before the scheduled admission or procedure.
- Hyperbaric Oxygen
- Infertility Testing or Treatment
- Infusion Therapy
- Inpatient Habilitation or Rehabilitation Facility
- Inpatient Hospital stay in excess of 48 hours for the mother and newborn child following a normal vaginal delivery and in excess of 96 hours for the mother and child following a cesarean section delivery
- Insulin Pumps
- Joint Procedures, including but not limited to joint replacement, joint reconstruction and joint injections.
- MRI, MRA, CTA, SPECT, FMRI, CAT and PET scan for selected diagnostic codes
- Neuropsychiatric Testing
- Non-emergent use of ground or air ambulance services
- Non-invasive stool DNA colorectal cancer screening tests
- Non-Network Provider services where a service is a covered benefit, and Medically Necessary, and a contracted network provider does not exist
- Nuclear imaging
- Orthodontia and prosthodontics when Medically Necessary Outpatient ECT (electroconvulsive therapy)
- Pharmaceutical medications rendered in a Physician's office or Home Health setting

- Radiation Therapy, including gamma knife
- Reconstructive Services
- Sick newborn nursery care
- Skilled Nursing Facility
- Sleep Studies
- Spine Care relating to neck and back conditions, including:
  - surgery,
  - epidurals,
  - facet and trigger point injections,
- Surgery
  - Inpatient
  - Outpatient
  - Ambulatory
  - Cyber Knife/ASC
  - Intraoperative Monitoring including Surgical Neuromonitoring
- Temporomandibular Joint Dysfunction treatment
- Therapeutic injections
- Transplants and transplant related services (including pre and post transplant testing)
- Upper Gastrointestinal (GI) Endoscopy, including monitored anesthesia for deep sedation for Upper Gastrointestinal (GI) Endoscopy
- Urine Drug Tests if testing exceeds more than 12 tests in a calendar year period

The Pre-authorization review process requires the full cooperation of the requesting Physician in order for Us to evaluate all of the pertinent information and make a coverage determination. We must make Our decision within 15 days business days of receiving the Prior Authorization request and Physician's statement. You can request an expedited exception if you or your Physician believe that your health could be seriously harmed by waiting 15 business days for a decision. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get the supporting statement from your Physician.

The results of the coverage determination will be communicated to You and Your Physician by the end of the second business day after receipt of the request. Coverage determinations are made based on the services reported to Us. If the reported services differ from those actually received, Our final coverage determination will be modified to account for those differences and We will only pay Benefits based on the services actually delivered to You.

If the Pre-authorization process is not followed, it could result in the delay or denial of claims payments.

IF YOU DO NOT OBTAIN THE NECESSARY PRE-AUTHORIZATION PRIOR TO SCHEDULING SERVICES, THOSE SERVICES WILL BE DENIED AS NOT BEING PREAUTHORIZED.

REQUESTS FOR RETROACTIVE PRE-AUTHORIZATION OF SERVICES MORE THAN 180 DAYS AFTER THE DATE OF SERVICE WILL BE DENIED.

Care Management

When We receive a request for Pre-authorization of health care services We may work with You to implement the Care Management process and to provide You with information about additional services that are available to You, such as disease management programs, health education, and patient advocacy.

All Care Management decisions are made by only qualified licensed professionals trained to assess the clinical information used to support Care Management decisions. Our Care Management decision-making is based only on appropriateness of care and service and existence of coverage, and that there are no financial incentives that encourage decisions that result in underutilization. We do not reward practitioners, referring Physicians, or Care Management decision makers for issuing denials of coverage.

Decide What Services You Should Receive

Care decisions are between You and Your health care provider. We do not make decisions about the kind of care You should or should not receive.

Show Your ID Card

You should show Your identification (ID) card every time You request health services. If You do not show Your ID card, the provider will fail to bill the correct entity for the services delivered, and any resulting delay may mean that You may be unable to collect any Benefits otherwise owed to You. The billing address used is based on the plan under which Your coverage is issued; therefore, it is important that You verify that Your provider has the correct billing information on file for Your plan.

Member Cost Sharing Requirements

Cost-sharing amounts include deductibles, coinsurance, copayments and any other expense required of a Member. Depending on the type of care You receive, and where you receive care, Your cost-sharing amounts will differ.

Refer to the *Schedule of Benefits (Who Pays What) section of this Policy* to determine what Your cost-sharing requirements are.

Annual Deductibles are the amount You must pay towards any Allowed Amounts for Covered Health Services incurred in a calendar year, before We will begin paying for Benefits.

Coinsurance is the percentage of any Allowed Amount that You are required to pay for certain Covered Health Services.

Copayments are the charge stated as a set dollar amount that You are required to pay for certain Covered Health Services.

Out-of-Pocket Maximum is the maximum amount of Deductible, Coinsurance, or Copayments You pay every calendar year.

Section 7 - Benefits/Coverage (What is Covered)

Benefit Determinations

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service You receive. Our decisions are for payment purposes only. We do not make decisions about the kind of care You should or should not receive. You and Your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations, and exclusions set out in this *Policy* which includes the Schedule of Benefits and any Amendments.
- Make factual determinations related to Benefits.

When receiving emergency care from a Non-Network Provider in a Non-Network facility, payment from the Plan will be limited to the Allowable Amount. The Allowable Amount is the amount negotiated by Us with the Non-Network Provider, or up to 160% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, whichever is less.

We may delegate this discretionary authority to other persons or entities that provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time at Our discretion. In order to receive Benefits, You must cooperate with those service providers.

Our Reimbursement Policies

We develop reimbursement policy guidelines, at Our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association (AMA), and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that We accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse, and fraud reviews), Our reimbursement policies are applied to provider billings. Network Providers are contractually obligated to follow Our reimbursement policies and may not balance bill for denials based on Our reimbursement policies.

You will be held harmless for Covered Health Services provided at a Network facility. Services provided by a Non-Network Provider at an In-Network facility, will be reimbursed according to Network reimbursement policies and at no greater cost to You than if services were provided by a Network Provider. This protection shall not apply for emergency services rendered at a Non-Network facility by Non-Network Providers.

Our reimbursement policies are available upon request for review. To obtain a copy of Our reimbursement policies, contact Customer Service at the telephone number listed in Section 3 of this Policy and on the back of Your ID card.

Explanation of Covered Health Services

Coverage is available only if all of the following are true:

- Services or supplies are Medically Necessary and for the purpose of diagnosing or treating a Sickness, Injury, or associated symptoms, unless otherwise specified
- Covered Health Services are received while this Policy is in effect
- Covered Health Services are received prior to the date that any of the individual termination

conditions listed in the *Termination/Nonrenewal/Continuation Section of this Policy*
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in this Policy.

This section describes Covered Health Services for which Coverage is available. Please refer to the *Schedule of Benefits (Who Pays What) section of this Policy* for details about:
- The amount You must pay for these Covered Health Services (including any Annual Deductible, Copayment, and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day, and dollar limits on services).
- Any limit that applies to the amount You are required to pay in a calendar year (Out-of-Pocket Maximum).

Note: *In listing services or examples, when We say, "this includes," it is not Our intent to limit the description to that specific list. When We do intend to limit a list of services or examples, We state specifically that the list "is limited to."*

All Covered Health Services are subject to the terms and conditions of this Policy, including any limitations or exclusion included in the *Limitations/Exclusions (What is Not Covered) section*.

Listing of Covered Health Services

Please refer to *Section 6 - How to Access Your Services and Obtain Approval of Benefits* to determine whether services listed below require Pre-Authorization.

Accident Related Dental Services

Outpatient Services, physician Home Visits and Office Services, Emergency Care and Urgent Care services received at an Urgent Care Center for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:
- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia

Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support, and are functional in the arch.

Ambulance Services

Covered Health Services under this section include:

Emergency ground or air ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) between facilities **only** when the transport is a result of any of the following:

- Transfer from a Non-Network Hospital/facility to a Network Hospital/facility.
- Transfer to a Hospital that provides a higher level of care than was available at the original Hospital/facility.
- Transfer to a more cost-effective acute care facility.
- Transfer from an acute facility to a sub-acute facility/setting.

Non-emergent air transportation requires Pre-Authorization.

Autism Spectrum Disorders (ASD)
Covered Health Services under this section include coverage for the assessment, diagnosis, and treatment of Autism Spectrum Disorder. Treatment covered includes:
- Evaluation and assessment services;
- Behavior training and management and applied behavior analysis, including but not limited to consultations, direct care, supervision, or treatment, or any combination thereof, provided by autism services providers;
- Habilitative or rehabilitative care, including, but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies. The level of benefits for occupational therapy, physical therapy, or speech therapy shall exceed the limit of twenty visits for each therapy if such therapy is medically necessary to treat autism spectrum disorders;
- Psychiatric care;
- Psychological care, including family counseling;
- Pharmacy and medication as covered under the terms of this Policy.
- Therapeutic care, which includes behavioral analysis; Habilitative or Rehabilitative Services.

Medically Necessary therapeutic care is not subject to the visit limitations noted on the Schedule of Benefits.

Any treatment for Autism Spectrum Disorder must be deemed Medically Necessary.

Early intervention services shall not duplicate or replace treatment for Autism Spectrum Disorder. Services for the treatment of Autism Spectrum Disorder shall be considered the primary service to an Eligible Child, and early intervention services shall supplement, but not replace, Autism Spectrum Disorder services.

Bariatric Surgery
Covered Health Services under this benefit include bariatric surgery that modifies the gastrointestinal tract with the purpose of decreasing weight. Before pursuing bariatric surgery, a complete nutritional, behavioral and medical evaluation must be completed and requirements must be met. You must meet Our medical criteria in order to be eligible for Bariatric Surgery.

Biologically Based Mental Illness and Mental Disorders
Covered Health Services under this section provides coverage for the treatment of Biologically Based Mental Illness Mental Disorders.

Biologically based Mental Illness means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.
Mental disorder means posttraumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, anorexia nervosa, bulimia nervosa, and general anxiety disorder.

Chemotherapy Services - Outpatient
Covered Health Services under this section includes intravenous chemotherapy treatment received on an outpatient basis at a Hospital or Alternate Facility.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:
- Education is required for a disease in which patient self-management is an important

component of treatment.
- There exists a knowledge deficit regarding the disease that requires the intervention of a trained health professional.

Benefits under this section include:
- The facility charge and the charge for related supplies and equipment.

Physician services for anesthesiologists, pathologists, and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services* provision of the *Benefits/Coverages (What is Covered) section of this Policy*.

Children's Dental Anesthesia
Covered Health Services under this section include general anesthesia when rendered in a Hospital, outpatient surgical facility, or other licensed facility, and associated Hospital and facility charges for dental when the child has a physical, mental, or medically compromising condition, has dental needs that would make local anesthesia ineffective because of anatomic variations, infection or allergy, or is extremely uncooperative, unmanageable, anxious or uncommunicative.

For the purposes of this Benefit, coverage is limited to Enrolled Children who are under 19 years of age.

Chiropractic Care
Covered Health Services include the therapeutic application of manual manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain, and improve function. The items listed below are Covered Health Services, regardless of the license the provider performing the services holds.

- Services and supplies for analysis and adjustments of spinal subluxation.
- Diagnosis and treatment by manipulation of the skeletal structure.
- Muscle stimulation by any means (except treatment of fractures and dislocations of the extremities).

Services are limited to 20 visits per calendar year.

Circumcision of Newborn Males
The Plan will cover circumcision of newborn males whether the child is natural or adopted or in a "placement for adoption" status.

Cleft Lip and Cleft Palate Treatment
Covered Health Services under this section include the following services when provided by or under the direction of a Physician in connection with cleft lip and/or cleft palate:
- Oral and facial surgery, surgical management, and follow-up care by a plastic and/or oral surgeon.
- Medically Necessary orthodontic services.
- Prosthodontic treatment.
- Habilitative speech therapy.
- Prosthetic devices such as obturators, speech appliances, and feeding appliances.
- Otolaryngological services.
- Audiological services.

Clinical Trials
Covered Health Services under this section include routine patient care costs during a clinical trial if:
- The treating Physician, recommends participation in the clinical trial after determining that participation in the clinical trial has the potential to provide a therapeutic health benefit to the Covered Person;
- The Covered Person suffers from a condition that is disabling, progressive, or life threatening;
- The clinical trial or study is approved under the September 19, 2000, Medicare national

coverage decision regarding clinical trials, as amended;

- The patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice, and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner; and
- Prior to participation in a clinical trial or study, the Covered Person has signed a statement of consent indicating that the Covered Person has been informed of the procedure to be undertaken, alternative methods of treatment, the general nature, and extent of the risks associated with participation in the clinical trial or study.

The coverage is subject to all terms and conditions of this Policy.

The coverage does not include:

- Any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;
- Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
- Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing, and other expenses that the Covered Person or person accompanying the Covered Person may incur;
- An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the Covered Person;
- Costs for the management of research relating to the clinical trial or study; or
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the Covered Person's health plan.

Nothing should preclude a carrier from asserting the right to seek reimbursement from the entity conducting the clinical trial or study for expenses arising from complications caused by a drug or device used in the clinical trial or study.

*"**Clinical trial**"* means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

(A) Federally Funded Trials- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  (i) The National Institutes of Health.
  (ii) The Centers for Disease Control and Prevention.
  (iii) The Agency for Health Care Research and Quality.
  (iv) The Centers for Medicare & Medicaid Services.
  (v) cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.
  (vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  (vii) Any of the following if the conditions described in paragraph (2) are met:
    (I) The Department of Veterans Affairs.
    (II) The Department of Defense.
    (III) The Department of Energy.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

*"**Routine patient care cost**"* means all items and services that are a benefit under a health coverage plan that would be covered if: 1) the Covered Person were not involved in either the experimental or the control arms of a clinical trial; except the investigational item or service, itself; 2) items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; 3) items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; 4) items or services that are typically provided absent a clinical trial; 5) items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of

service, or the prevention of complications; and 6) items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

Congenital Defect and Birth Abnormalities
Covered Health Services under this section include necessary treatment and care of medically diagnosed congenital defects and birth abnormalities.

Physical, occupational, and speech therapy for the care and treatment of congenital defect and birth abnormalities for children age 3 to 6 are covered. Short-term outpatient rehabilitation services are limited to twenty (20) therapy visits per calendar year each for physical therapy, occupational therapy, and speech therapy. Said therapy visits may be distributed as medically appropriate throughout the yearly term of the Policy without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

Rehabilitation services must be performed by a Physician or by a licensed therapist. Benefits under this section include rehabilitation services provided in a Physician's office, on an outpatient basis, or at a Hospital or Alternate Facility.

Custom Shoes for Diabetics
Covered Health Services under this section include one pair of custom shoes per calendar year as prescribed by a Physician in relation to the diagnosis of diabetes.

Diabetes Services
Covered Health Services under this section include the following:

- Outpatient self-management training, education, and medical nutrition therapy services ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.
- Medical eye examinations (dilated retinal examinations) for Covered Persons with diabetes
- Preventive foot care for Covered Persons with diabetes.
- Diabetic shoes.
- One Insulin pump every three (3) years will be covered at 100% of the Allowed Amount and is not subject to the Annual Deductible, Copayment, or Coinsurance. Any supplies used in conjunction with the insulin pump will be subject to the *Durable Medical Equipment* provision.

Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets, and lancet devices are subject to the *Outpatient Prescription Drug* provision. Brands for these supplies may be determined at Our sole discretion.

See the *Custom Shoes for Diabetics* provision above for additional coverages.

Dialysis Services - Outpatient
Covered Health Services under this section includes dialysis (both hemodialysis and peritoneal dialysis) treatments received on an outpatient basis at a Hospital or Alternate Facility.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease that requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.

Physician services for anesthesiologists, pathologists, and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services* provision of the *Benefits/Coverages (What is Covered) section of this Policy*.

Durable Medical Equipment
Covered Health Services under this section include Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to You by a Physician.

If more than one piece of Durable Medical Equipment can meet Your functional needs, Coverage is available only for the equipment that meets the minimum specifications for Your needs. Coverage is for medically appropriate equipment only, and does not include special features, upgrades or equipment accessories. If You rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, You will be responsible for any cost difference between the piece You rent or purchase and the piece We have determined is the most cost-effective.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair, once every 5 years
- A standard Hospital-type bed, once every 5 years
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors, and masks).
- Delivery pumps for tube feedings
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Nebulizers and Peak Flow Meters. Coverage under this plan includes the purchase of one (1) nebulizer in a calendar year period, or one (1) rental per episode, and the purchase of (1) peak flow meter. We will determine if the nebulizer is purchased or rented. Charges are covered at 100% of the Allowed Amount and are not subject to the Annual Deductible, Copayment, or Coinsurance. Coverage is available for repairs and replacement, except that:
- Coverage for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect. Established guidelines by Medicare are followed for the lifetime of Durable Medical Equipment. Equipment is expected to last at least five (5) years.
- Coverage is not available to replace lost items.

Replacement of Durable Medical Equipment solely for warranty expiration, or new and improved equipment becoming available is not covered. Duplicate or extra Durable Medical Equipment for the purpose of the member's comfort, convenience, or travel is not covered. Durable Medical Equipment Benefits do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

We may limit the quantities of certain Durable Medical Equipment to an amount considered to be reasonable for a specific period of time. When quantities exceed what We consider reasonable for a given time frame, there must be an explanation of the Medical Necessity for the quantities. If this information is not provided to Us, there may be a delay in processing the claim or the claim may be denied.

Early Intervention Services
Covered Health Services under this section include early intervention services as defined by the Division (the unit within the Department of Human Services that is responsible for developmental disabilities services) in accordance with part C of the federal "Individuals with Disabilities Education Act", 20 U.S.C. sec. 1400 et seq. and that are authorized through an Eligible Child's individualized family service plan and provided by a qualified early intervention service provider.

The following services are excluded from coverage under this benefit:
- Non-emergency medical transportation;
- respite care;
- service coordination, as defined in 34 CFR 303.12 (d) (11); and
- assistive technology, unless otherwise covered under this Policy.

Early intervention services shall not duplicate or replace treatment for Autism Spectrum Disorders. Services for the treatment of Autism Spectrum Disorders shall be considered the primary service to an Eligible Child and early intervention services shall supplement, but not replace, Autism Spectrum Disorder services.

Covered at 100% of the Allowed Amount and are not subject to the Annual Deductible, Copayment, or Coinsurance.

Emergency Health Services
Covered Health Services under this section include services required to stabilize or to initiate treatment in an Emergency situation. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies, and all professional services required to stabilize Your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring Your condition (rather than being admitted to a Hospital for an Inpatient Stay). Professional Services include services rendered by the Emergency room Physicians, consulting Physicians, pathologists, radiologists, and anesthesiologists.

All Covered Health Services for Emergency Health Services will be reimbursed according to Network reimbursement policies, regardless of the Network status of the billing provider. Charges for Emergency Health Services received by a Non-Network Provider will be reimbursed to the provider at an amount equivalent to the in-network reimbursement rate. You may be billed by Non-Network Providers for Emergency Health Services for amounts in excess of what We reimburse the Non-Network Provider.

If You are admitted to a Non-Network facility through the emergency room, You, your Physician or Hospital must notify Us within 48 hours, or as soon as reasonably possible. Upon stabilization, We will move You by ambulance to the nearest appropriate In-Network or Participating facility.

If You are admitted to a hospital from the emergency room, Your emergency room Copay, if applicable, will be waived.

Benefits under this provision are not available for services to treat a condition that does not meet the definition of an Emergency.

Eye Care Services
Covered Health Services under this section include services related to the examination, diagnosis, treatment, and management of a medical condition, accidental injury or disease of the eye(s) and related structures. Routine eye care is covered only for dependent children under age 19.

Foot Care
Covered Health Services under this section include foot care services when performed specifically for the purpose of treating pain related to functional limitations. These services include routine foot care, such as cutting or removal of corns and calluses or nail trimming, cutting, or debriding.

Gender Identity & Gender Transition Services
Covered Health Services under this section include Medically Necessary medical, behavioral health and surgical services in relation to gender dysphoria, gender identity, gender transition and reassignment. Covered services may include supportive mental health counseling and treatment of any additional co-morbid mental health conditions, appropriate hormonal treatment interventions, orchiectomy, oophorectomy and hysterectomy, as well as genital reconstructive surgery where those interventions and treatments comply with all other provisions of the Plan, such as Pre-authorization. Failure to obtain the Pre-authorization prior to receiving care may result in services not being covered.

Covered Health Services **will not** include any service considered to be cosmetic or not Medically Necessary including but not limited to hair replacement or removal, voice therapy or lessons, liposuction, rhinoplasty, liposuction, breast augmentation, laryngeal or thyroid cartilage shaving or contouring, abdominoplasty, chest wall contouring, facial contouring, collagen injections and any other cosmetic procedure or service otherwise excluded under the Plan. Travel expenses related to surgery are also not covered.

Appropriate screening services covered under the plan will continue to be a Covered Health Service subject to all other terms and provisions of the Plan regardless of gender assignment including but not limited to mammograms.

Due to the limited number of Providers that offer these services, We recommend that You contact Us before seeking care. We want to ensure that you are navigated to appropriate providers and that any required authorizations are in place so that your services are not inappropriately denied.

Genetic Testing
Covered Health Services under this section includes charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease.

Genetic testing is covered only if:

- The Covered Person has symptoms or signs of a genetically-linked inheritable disease;
- It has been determined that a Covered Person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.
- The services are in accordance with the A or B recommendations of the U.S. Preventive Services Task Force.

Genetic counseling is covered if an Insured Person is undergoing approved genetic testing or if an Insured Person has an inherited disease and is a potential candidate for genetic testing.

Hearing Aids (Minor Children)
Covered Health Services under this section include hearing aids for an Eligible Child under age 18, who has a hearing loss that has been verified by a licensed Physician or by an audiologist. The hearing aids shall be medically appropriate to meet the needs of the Eligible Child according to accepted professional standards. Coverage shall include the purchase of the following:
- Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
- A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the Eligible Child;
- Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

High Tech Diagnostic Imaging, Nuclear Medicine, and Major Diagnostic Services - Outpatient
Covered Health Services under this section include CT scans, PET scans, MRI, MRA, nuclear medicine, or major diagnostic services received on an outpatient basis at a Hospital, Alternate

Facility.

Coverage under this section includes charges for:
- The facility;
- Supplies and equipment; and
- Physician services.

Home Health Care
Covered Health Services under this section include services received from a Home Health Agency that is both of the following:
- Ordered by a Physician.
- Provided in Your home by a certified home health agency.

Coverage is available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule, and when skilled care is required.

Skilled Care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:
- It must be delivered or supervised by a licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if coverage is available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Home health services include skilled care, therapies (physical, occupational, speech, respiratory and inhalation), social work services, medical supplies furnished by the Home Health Agency during visits, nutrition counseling by a nutritionist or dietician, home health aide services that are supervised by a registered nurse or licensed therapist, prosthesis and orthopedic appliances, and Durable Medical Equipment.

Services may not exceed 28 hours per week combined over any number of days per week; and must be for less than eight (8) hours per day.

Hospice Care
Covered Health Services under this section include hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill.

Coverage is available when hospice care is received from a licensed hospice agency.

Hospice care includes:
- Routine home care hospice services.
- Short-term general inpatient hospice care or continuous home care hospice services, which may be required during a period of crisis, for pain control or symptom management.
- Intermittent non-routine respite care on a short-term basis of five (5) days or less.

Hospice care also includes physical, psychological, social, and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Refer to Your Mental Health and Substance Abuse – Outpatient benefit for information on grief counseling.

Hospital and Free-Standing Facility Services
Covered Health Services under this section include services and supplies related to the care and treatment of a Sickness or Injury received during an Inpatient hospital stay, Outpatient procedure or evaluation, or in an emergency room. Coverage is available for:

- A Hospital room with two (2) or more beds. If a private room is used, We will allow only up to the prevailing 2 bed room rate, unless a private room is Medically Necessary.
- Care in Special Care Units such as Intensive Care, Cardiac Care, Neonatal Care, when Medically Necessary
- Operating rooms, delivery rooms and special treatment rooms
- Supplies and services such as laboratory, cardiology, pathology and radiology received while in the Hospital
- Drugs, medicines and oxygen provided during your stay
- Blood, blood plasma, blood derivatives and blood factors, blood transfusions including blood processing and storage costs.

Infertility Services
Coverage under this section includes coverage for the following Services, including X-ray and laboratory procedures:

- Services for diagnosis and treatment of involuntary infertility; and
- Artificial insemination, except for donor semen, donor eggs and Services related to their procurement and storage.

Infusion Therapy Services - Outpatient
Covered Health Services under this section includes intravenous infusion therapy treatment received on an outpatient basis at a Hospital or Alternate Facility.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease that requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.

Physician services for anesthesiologists, pathologists, and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services* provision of the *Benefits/Coverages (What is Covered) section of this Policy*.

Inpatient Rehabilitative and Habilitative Service
Covered Health Services under this section include services and supplies provided during an Inpatient Stay in an Inpatient Rehabilitation Facility and coverage is available for:

- Services, supplies, and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for anesthesiologists, consulting Physicians, pathologists, and radiologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services provision of the *Benefits/Coverages (What is Covered) section of this Policy*.)
- Skilled rehabilitation and habilitation services when all of the following are true:
  - It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
  - It is ordered by a Physician.
  - It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair.
  - It requires clinical training in order to be delivered safely and effectively.

We will determine if coverage is available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Please note that coverage is available only if both of the following are true:

- If the initial confinement in an Inpatient Rehabilitation Facility was or will be a cost-effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Lab, X-Ray, and Diagnostic Services - Outpatient

Covered Health Services under this section include laboratory, x-ray, and radiology services performed for diagnostic purposes received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office.

Coverage under this section includes charges for:

- The facility;
- Supplies and equipment; and
- Physician services.

Lab, X-ray, and diagnostic services for preventive care are described under *Preventive Care Services provision*.

Medical Supplies and Disposable Items

Covered Health Services under this section include disposable medical supplies suitable for use in the home.

Some Covered items may include:

- Ostomy Supplies
  - Pouches, face plates, and belts.
  - Irrigation sleeves, bags, and catheters.
  - Skin barriers
- Tubing and connectors for delivery pumps
- Burn garments
- Supplies related to insulin pumps

We may limit the quantities of certain supplies to an amount considered to be reasonable for a thirty (30) day period. When quantities exceed what We consider reasonable for a given time frame, there must be an explanation of the Medical Necessity for the quantities. If this information is not provided to Us, there may be a delay in processing the claim or the claim may be denied.

Mental Health and Substance Abuse Services - Inpatient and Intermediate

Covered Health Services under this section include Mental Health and Substance Abuse Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Benefits include treatment of Mental Illness and Substance Abuse whether treatment is voluntary on the part of the Covered Person or court ordered as the result of contact with the criminal justice or legal system.

Covered Benefits also include short-term grief counseling for immediate family members while a Covered Person is receiving Hospice Care.

Mental Health and Substance Abuse Services – Outpatient

Covered Health Services under this section include Mental Health and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Mental health, Substance Abuse, and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.

- Referral services.
- Medication management.
- Short-term individual, family, and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention.

Benefits include the treatment of Mental Illness and Substance Abuse whether treatment is voluntary on the part of the Covered Person or court ordered as the result of contact with the criminal justice or legal system.

Pediatric Dental Care
This benefit is only available when services are received from a Network Provider. There are no Benefits for services received from a Non-Network Provider. The number and frequency of each of these services are limited.

For the purposes of this Benefit, coverage is limited to Enrolled Children who are under 19 years of age. Pediatric Dental coverage ends the last day of the month in which the child turns age 19.

Covered Health Services under this section include the following:
- Diagnostic and preventive procedures, which must include:
  - Oral exams and evaluations;
  - Full mouth, intra-oral, and panoramic x-rays;
  - Bitewing x-rays;
  - Routine cleanings;
  - Fluoride treatments;
  - Space maintainers;
  - Sealants; and
  - Palliative treatment.
- Basic restorative services, which must include:
  - Amalgam fillings;
  - Resin and composite filings;
  - Crowns;
  - Pin retention; and
  - Sedative fillings.
- Oral surgery, consisting of extractions.
- Endodontics, consisting of:
  - Surgical periodontal services; and
  - Root canal therapy.
- Medically Necessary orthodontia and Medically Necessary prosthodontics.

Implants, denture repair and realignment, dentures and bridges, non-Medically Necessary orthodontia, and periodontics are not covered under this benefit provision.

The number and frequency of each of these services are limited. ***See the Schedule of Benefits for limitations and reimbursement levels***.

Pediatric Vision Care
This benefit is only available when services are received from a Network Provider. There are no Benefits for services received from a Non-Network Provider.

For the purposes of this Benefit, coverage is limited to Enrolled Children who are under 19 years of age.

Covered Health Services under this section include routine vision examinations, including refractive examinations to determine the need for vision correction when they are provided by a Network Provider. One vision examination is covered each calendar year.

Covered Health Services under this section also includes one pair of eyeglasses, including frames and lenses, or contact lenses, every 2 years. Contact lenses are limited to a one-year supply per calendar year.

Pharmaceutical Products – Outpatient
Covered Health Services under this section include Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Coverage under this section is provided only for Pharmaceutical Products which, due to their characteristics (as determined by Us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Coverage under this section does not include medications that are typically available by Prescription Order or Refill at a pharmacy.

Phenylketonuria (PKU) and other Inherited Enzymatic Disorder Testing and Treatment
Covered Health Services under this section include testing for Phenylketonuria (PKU) and is covered to prevent the development of serious physical or mental disabilities, or to promote normal development or function as a consequence of PKU enzyme deficiency. Medical Foods, for the purpose of this Benefit, refer exclusively to prescription metabolic formulas and their modular counterparts, obtained through a pharmacy. Medical foods are specifically designated and manufactured for the treatment of Inherited Enzymatic Disorder caused by Single Gene Defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions.

Coverage for Inherited Enzymatic Disorders includes care and treatment of such conditions shall include, to the extent Medically Necessary, Medical Foods for home use for which a participating Physician has issued a written, oral, or electronic prescription. Benefits for Medical Foods are described under the *Outpatient Prescription Drug* provision of the *Benefits/Coverages (What is Covered) section of this Policy*.

There is no age limit on Benefits for Inherited Enzymatic Disorders except for phenylketonuria. The maximum age to receive Benefits for phenylketonuria is 21 years of age; except that the maximum age to receive Benefits for phenylketonuria for women who are of childbearing age is 35 years of age.

Physician Fees for Surgical and Medical Services
Covered Health Services under this section include physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

When these services are performed in a Physician's office, Benefits are described under *Physician's Services for Sickness and Injury.*

Second opinions are subject to payment of any applicable Copayments or Coinsurance. You may get a second opinion from a Plan Physician about any proposed covered Services.

Physician's Services for Sickness and Injury
Covered Health Services under this section include services provided by a Physician's for the diagnosis and treatment of a Sickness or Injury. Coverage is provided under this section regardless of whether the Physician's office is freestanding, provided as a home visit, located in a clinic, located in a Hospital, or provided as Telemedicine.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease, which requires the intervention of a trained health professional.

Covered Health Services for Preventive Care provided in a Physician's office are described under *Preventive Care Services*.

Clinic Fees
For Physician's Office Services received at an Outpatient Clinic that is owned by a hospital, a clinic fee may be billed by the Provider. This fee is not covered as part of the Office Visit. Your Deductible and Coinsurance will apply to Clinic Fees.

Note: *When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/x-rays, and other diagnostic services that are performed outside the Physician's office are described in the Lab, X-ray and Diagnostics – Outpatient provision of the Benefits/Coverages (What is Covered) section of this Policy.*

Pregnancy – Maternity Services
Covered Health Services under this section include Benefits for Pregnancy and includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related Complications of Pregnancy. This includes charges for a certified nurse midwife.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. Benefits include genetic counseling and testing when there is a reasonable probability that, because of the family history, parental age, or exposure to an agent, which might cause birth defects or cancer in the fetus, the results will affect medical decisions involving the existing Pregnancy. These are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We will pay Benefits for a stand-alone birthing center or for an inpatient Hospital stay of at least:
- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

Please Note: If 48 or 96 hours following delivery falls after 8 pm, coverage shall continue until 8 am the following morning.

Coverage is provided for well-baby care in the Hospital or at a stand-alone birthing center, including a newborn pediatric visit and newborn hearing screening.

Statement of Rights under the Newborns' and Mother's Health Protection Act
Group health plans and health insurance issuers generally may not, under Federal law, 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. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Prescription Drugs
We use a Pharmacy Services Vendor to help manage the Prescription Drug benefit. Your cost and coverage of Prescription Drug Products from this benefit is impacted by the following factors:
- Eligibility at the time of service;
- The pharmacy filling Your prescription;
- The status of the medication on Our Formulary, its brand or generics status, its status as a Specialty Pharmacy medication; and
- Annual Deductibles, Copayments, Coinsurances, Days' Supply Limits, and other Quantity or Supply Limits.

Identification Card required for Prescription Services
You must show Your ID Card at the time You obtain Your Prescription Medications. The information on Your ID Card helps the pharmacy filling Your prescriptions verify that You are eligible, and

determine the coverage and cost of Prescription Medications according to this benefit.

If the pharmacy does not have the necessary information from Your ID Card, it will not be able to provide prescriptions according to Your benefit. If You use a network pharmacy but do not use Your ID Card, You may be asked to pay the pharmacy's requested or Usual and Customary price for the medication. You will need to submit a claim to for us to consider the prescription for reimbursement under Your benefits. You will always be responsible for any deductibles, co-pays, coinsurance, or other benefit limits under this benefit. Only Pharmacies that participate in our Pharmacy Network are able to fill Your prescriptions under this benefit.

Pharmacy Network

You must use a Network Pharmacy to receive Benefits under this Policy. If You do not use a Network Pharmacy, You have no coverage under this benefit. To find a Network Pharmacy, visit Our website at www.brighthealthplan.com or call the Customer Service number listed on Your ID Card.

Specialty Pharmacy

Specialty Medications are prescribed to treat serious or chronic medical conditions such as but not limited to multiple sclerosis, hemophilia, hepatitis and rheumatoid arthritis. These medications may be oral or injectable. They can be self-administered or administered by a family member.

We have a program for specialty medications through a Specialty Pharmacy Network. If You need specialty medications, You must use one of the providers in the Specialty Pharmacy Network as Your specialty medication pharmacy. You may also be required to have the medication administered in certain settings or facilities. Specialty medication providers are experts in supplying medications and services to patients with complex health conditions. They will give You information about Your condition and the medications that have been prescribed to You. Please call Customer Service at (800) 237-2767 to find out which providers are in the Specialty Pharmacy Network program.

Mail order medications / Network Benefits

Self-administered medications must be obtained through the Plan's pharmacy benefit. You may get outpatient formulary prescription medications which can be self-administered through the mail order pharmacy service or from a retail pharmacy.

New prescriptions to treat certain chronic conditions and trial medications will be limited to quantity limits described at the end of this section.

Formulary List

Our Pharmacy and Therapeutics committee has created a list of Prescription Drug Products for this Plan, called a Formulary. The Formulary is referenced to determine what You pay at the pharmacy for covered Prescription Drug Products under the Plan. Products on the Formulary are covered differently than products not listed on the Formulary. Your cost for prescriptions will vary depending on the Formulary status of each specific medication. In general, medications on the Formulary are intended to cost You less than medications not on the Formulary. The Formulary contains both Brand-Name and Generic medications.

We may periodically change the status of a medication on the Formulary. These changes may occur without prior notice to You. Additionally, the status of a medication may change from brand to Generic. Brand name or Generic product status may impact Your costs and coverage under this benefit.

You may view the Formulary at Our website www.brighthealthplan.com or contact the Pharmacy Customer Service at the number listed on Your ID Card to request a copy.

Quantity Limit or Supply Limits

Your prescriptions may be limited by quantity, management, or Supply Limits which may reduce the quantity of Your prescription to a 30-day supply versus the full quantity written by Your prescriber. Some Prescription Drug Products may be required through a Mail Order Network

Pharmacy. Mail order prescriptions will be eligible as written by the provider, up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size, or based on other Quantity or Supply Limits. Specialty Prescription Drug Products will be eligible as written by the provider, up to a consecutive 30-day supply of a Specialty Prescription Drug, unless adjusted based on the drug manufacturer's packaging size or based on other Quantity or Supply Limits. When a Specialty Prescription Drug Product is packaged or designed in a manner that provides more or less than a consecutive 30-day supply, the Copayment and/or Coinsurance that applies may be adjusted to reflect the number of days dispensed.

For certain medications, the plan limits the amount or dose of the medication that will be covered with each prescription or over a certain time period.

Limitation on Selection of Pharmacies

If we determine that You may be using Prescription Medications in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require You to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the designated single Network Pharmacy. If You don't make a selection within 31 days of the date we notify You, we will select a single Network Pharmacy for You.

Pre-Authorization

Some Prescription Drug Products may require Pre-Authorization to be covered. In these cases, Your Physician and/or pharmacist will be notified. They are instructed to call the number on Your ID Card, or follow directions provided in a communication. Pre-Authorization is used to verify that certain requirements have been met before coverage of a specific type of prescription is dispensed. Without Pre-Authorization approval, Your Prescription Drug Product may not be covered.

Step Therapy

Step Therapy encourages You to try less costly but just as effective drugs before the Plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the Plan may require you to try Drug A first. If Drug A does not work for you, the Plan will then cover Drug B. The requirement to try a different drug first is call "Step Therapy".

In order to find out which medications require Step Therapy, refer to the Formulary at www.brighthealthplan.com.

Pharmacy drug samples shall not be considered trial and failure of a preferred medication in lieu of trying the Step Therapy required medication.

Exceptions

Exceptions to above may be granted in certain circumstances or for emergency or special situations. Your prescriber or doctor and pharmacy staff will need to provide certain information in order for us to review an exception request. There is a process to appeal decisions, and You will receive that information if You are denied a claim.

If the plan does not cover Your medication or has restrictions or limits on Your medication that You don’t think will work for You, You can do one of these things:

- You can ask Your health care provider if there is another covered medication that will work for You; or
- You and/or Your health care provider can ask the plan to make an “exception” to cover a medication or to remove medication restrictions or limits. If We agree that the exception is Medically Necessary and the exception is approved, the medication will be covered at either:
  - the tier for the drug listed within the formulary document for formulary drugs; or
  - at the non-preferred brand tier for non-formulary drugs.

Examples of exceptions are:

- the medication that is normally covered has caused a harmful reaction to You;
- there is a reason to believe the medication that is normally covered would cause a harmful

reaction; or
- the medication prescribed by Your qualified health care provider is more effective for You than the medication that is normally covered.

The medication must be in a class of medications that is covered.

For standard exception requests, We must make a determination and notify You and the prescribing physician no later than 72 hours following Our receipt of the request for exception. If We grant a standard exception request, We must provide coverage of the non-formulary drug for the duration of the prescription, including refills.

For expedited exception requests, We must make a determination and notify You and the prescribing physician no later than 24 hours following Our receipt of the request for exception. Expedited exception requests are appropriate for exigent circumstances, which means the person for whom the request is being made is suffering from a health condition that may seriously jeopardize his or her life, health, ability to regain maximum function, or the person is undergoing a current course of treatment using a non-formulary drug. If We grant an exception based on exigent circumstances, We must provide coverage for the non-formulary drug for the duration of the exigency.

For additional information about the prescription drug exceptions processes for drugs not included on Your Plan's Formulary, please contact the Pharmacy Customer Services number on Your ID Card.

Off-label Cancer Medications

Covered Health Services under this section include the off-label use of a medication for the treatment of cancer.

Certain drugs may be used for the treatment of cancer even though the drug has not been approved by the Food and Drug Administration (FDA) for treatment of a specific type of cancer.

To qualify for Off-Label use, the drug must be recognized for the specific treatment for which the drug is being prescribed by one of the following four compendiums: (1) National Comprehensive Cancer Network (NCCN) Compendia; (2) American Hospital Formulary Service (AHFS) DrugDex, (3) LexiComp or (4) Clinical Pharmacology.

A Prescription Drug Product includes a drug approved by the FDA prescribed to treat cancer during certain clinical trials as described in the Policy.

Oral Anticancer Medication

Covered Health Services under this section include orally administered anticancer medication that has been approved by the Federal Food and Drug Administration (FDA) and is used to kill or slow the growth of cancerous cells. The orally administered medication shall be provided at a cost to the Covered Person not to exceed the Coinsurance percentage or the Copayment amount as is applied to an intravenously administered or an injected cancer medication prescribed for the same purpose. Orally administered anticancer medication shall be deemed Medically Necessary by the treating Physician for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent site, and duration and not primarily for the convenience of the Covered Person, Physician, or other health care provider.

The use of orally administered anticancer medications is not a replacement for other cancer medications.

Coverage will be paid according to the medication classification (i.e. Preventive, Generic, Preferred/Non-Preferred Brand Drugs or Specialty Prescription Drug Products) and subject to the terms of the Prescription Drug provision of the Benefits/Coverages (What is Covered) section of this Policy.

Your Prescription Drug benefit includes coverage for the following drug tiers:
Tier 1: Preventive Medications
Tier 2: Generic Medications
Tier 3: Preferred Brand Medications
Tier 4: Non-Preferred Brand Medications
Tier 5: Specialty Medications

Each of the tiers above may contain both brand or generic medications.

Some Specialty Medications are available in other tiers. Review our formulary at https://member.brighthealthplan.com to determine what tier your specialty medication falls in.

Refer to Your Schedule of Benefits for Your costs related to these drug tiers.

Covered Medications and Products

Covered products are subject to deductibles, copayments and/or coinsurance, Formulary status, brand or generic status, Specialty Prescription status, and pharmacy network status, as well as other Days Supply Limits, or Quantity or Supply Limits defined in Our formulary.

- Coverage is limited to prescription products, prescribed by a legal prescriber. Prescription Medications are labeled as "Caution: Federal Law Prohibits Dispensing without a Prescription", "Rx Only", and/or where Colorado recognizes such products as requiring a prescription or mandates coverage as such.
- Insulin is covered as a prescription product, along with syringes, and items required for monitoring diabetes treatment and testing strips, ketone urine test strips, lancets and related devices, pen delivery system for insulin administration, insulin syringes, visual aids to support the visually impaired with the proper dosing of insulin (except eyewear), Prescription Medications for treatment of diabetes (oral medications), glucagon.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins when a prescription is required for dispensing, to prevent or treat a specific medical condition.
- Compounded medications are covered when dispensed by a network pharmacy, and contain at least one prescription product for treatment of a covered condition, which has no commercially available prescription alternative. The Plan will cover the formulary prescription contents of the compounded medication. Any over the counter medications or ingredients included in the compound are not covered.
- Phenylketonuria (PKU) formulas and special food products are covered, and subject to the same deductibles, co-pays, and network providers as other prescription products, when used to treat PKU.
- Specialty Pharmaceutical medications, as defined by the plan when dispensed by our Specialty Pharmacy Network Supplier.
- Contraceptives medications, devices, and various other products are covered for use as birth control.
- Immunizations administered at a Network Pharmacy.
- Medications prescribed to treat emergency medical conditions while traveling outside the United States.

We may limit the quantities of certain supplies to an amount considered to be reasonable for a thirty (30) day period. When quantities exceed what We consider reasonable for a given time frame, there must be an explanation of the Medical Necessity for the quantities. If this information is not provided to Us, there may be a delay in processing the claim or the claim may be denied.

Prescription Eye Drop Refills

Prescription eye drop refill renewals are allowed for a Covered Person if the refill is requested once 70% of the initial days' supply submitted by the pharmacy has been used. For example, after the first twenty-one days for a thirty-day supply of eye drops, forty-two days for a sixty-day supply of eye drops, or sixty-three days for a ninety-day supply of eye drops from the last date that the prescription was filled. One additional bottle of prescription eye drops will be allowed if a bottle is requested by the Covered Person or Provider at the time the original prescription is filled; and the

original prescription states that one additional bottle is needed by the insured for use in a day care center, school, or adult day program. The additional bottle is limited to one bottle every three months.

Prescription eye drop refill benefits are subject to the same annual Deductibles, Copayments, or Coinsurance amounts established for all other prescription drug benefits under the plan.

Preventive Medications

Covered Health Services under this section include preventive medications in accordance with the A or B recommendations of the U.S. Preventive Services Task Force:

- Aspirin
- Bowel preparation for colonoscopy screening generic and brand prescription and OTC preparations, two (2) per calendar year.
- Breast cancer preventive medications for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
- Contraceptives (Barrier/Diaphragms/Cervical caps, Hormonal, Emergency, Implantable, Intrauterine).
- Folic acid – Generic OTC and prescription products 0.4-0.8 mg for women planning or capable of pregnancy.
- Iron Supplements – Generic OTC and prescription products for children ages 6 to 12 months who are at risk for iron deficiency anemia.
- Low to moderate dose statin preventive medication for adults ages 40-75 with no history of cardiovascular disease for the prevention of cardiovascular disease events and mortality.
- Oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.
- Smoking Cessation medications
- Any other preventive medication included in the A or B recommendations of the task force or as required by state or federal law. For a complete list of Preventive Care services, please visit the U.S. Preventive Services Task Force website: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

Opioid Dependence

One time within a twelve (12) month period, We will provide coverage for a five-day supply of an FDA-approved medication without pre-authorization when the medication is being issued for the treatment of opioid dependence. Subsequent requests for the medication may require pre-authorization.

What You Must Pay

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table for generics, and for brand-name medications, non-formulary medications, and specialty prescription medications once the deductible is met.

Preventive and Wellness Services

Covered Health Services under this section include preventive health care services for the following, in accordance with the A or B recommendations of the U.S. Preventive Services Task Force.

When these services are received from a Network Provider, they are covered at 100% of the Allowed Amount and are not subject to the Annual Deductible, Copayment, or Coinsurance:

- Abdominal aortic aneurysm screening for men ages 65-75 years old and who have ever smoked;
- Alcohol misuse screening and counseling for adults age 18 or older. Persons engaged in risky or hazardous drinking will be provided with brief behavioral counseling interventions to reduce alcohol misuse.
- Bacteriuria screening with urine culture for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, if later;
- Bowel preparation for colonoscopy screening for men and women ages 50 to 76 years, Generic and brand prescription and OTC preparations, two (2) per calendar year.

- BRCA risk assessment testing for women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing;
- Breast cancer screening mammography for women with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.
- Breast cancer preventive medications for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
- Breastfeeding counseling, comprehensive lactation support, breast pump and supplies during pregnancy and after birth to promote and support breastfeeding;
- Cervical cancer screening in women ages 21 to 65 with cytology every 3 years, or for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years;
- Chicken pox vaccination for all persons who have not had chicken pox;
- Child health supervision services and childhood immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP);
- Chlamydia and Gonorrhea screening in sexually active women age 24 years or younger, and in older women who are at increased risk for infection;
- Cholesterol abnormalities screening in men age 35 years and older for lipid disorders, screening in men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease; screening in women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease, and screening in women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.
- Colorectal cancer screening coverage for all persons over age 50 for the early detection of colorectal cancer and adenomatous polyps, and for all individuals who are at a high risk for colorectal cancer including covered persons who have a family medical history of colorectal cancer, a prior occurrence of cancer or precursor neoplastic polyps, a prior occurrence of chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease or ulcerative colitis or other predisposing factors as determined by the provider. At home non-invasive stool DNA colorectal screening tests are subject to Medical Necessity and Pre-Authorization requirements.
- Contraceptive methods and counseling for all FDA approved contraceptive methods, sterilization procedures, and patient education and counseling for all women and men with reproductive capacity. All FDA approved methods of contraception are covered under this Policy without cost–sharing, as required by federal and state law. Such methods include sterilization surgery for women and men, implantable rods, intra uterine devices, shots or injections, formulary oral contraceptives, formulary birth control patches, formulary vaginal contraceptive rings and emergency contraception.
- Dental caries prevention for infants up to children age 5 including the application of fluoride varnish to the primary teeth. The USPSTF recommends Primary Care Physicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.
- Depression screening for major depressive disorder for adolescents age 12 to 18 years and screening for depression in the general adult population including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
- Diabetes screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese.
- Domestic and interpersonal violence screening and counseling, including intimate partner violence screening for women of childbearing age, and referral for women who screen positive to intervention services;
- Fall prevention including recommendations for exercise, physical therapy and vitamin D supplementation in community-dwelling adults age 65 years and older who are at increased risk for falls;
- Folic acid – Generic OTC and prescription products 0.4-0.8 mg for women planning or capable of pregnancy;
- Gestational diabetes mellitus screening in asympotmatic pregnant women after 24 weeks of

gestation;

- Gonorrhea prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.
- Healthy diet and physical activity counseling for overweight or obese adults to prevent cardiovascular disease, including behavioral counseling interventions for adults with additional cardiovascular disease risk factors;
- Hearing loss screening in all newborn infants;
- Hemoglobinopathies screening for sickle cell disease in newborns;
- Hepatitis B screening in pregnant women at their firs prenatal visit, and in nonpregnant adolescents and adults who are at high risk for infection.
- Hepatitis C screening in persons at high risk for infection, and also a one-time screening for adults born between 1945 and 1965;
- High blood pressure screening in adults age 18 or older;
- HIV screening and counseling for adolescents and adults ages 15 to 65 years, and to younger adolescents and older adults who are at increased risk, and pregnant women including those who present in labor who are untested and whose HIV status is unknown;
- Human papillomavirus (HPV) screening and vaccine;
- Hypothyroidism screening for congenital hypothyroidism in newborns;
- Immunizations in accordance with the Immunization Schedules of the ACIP that have been adopted by the Centers for Disease Control and Prevention for children 0 to 6 years, for children age 7 to 18 years, a “catch-up” schedule for children and adults;
- Influenza and pneumococcal vaccinations pursuant to the schedule established by ACIP
- Iron Supplements – Generic OTC and prescription products for children ages 6 to 12 months who are at risk for iron deficiency anemia.
- Lung cancer screening with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.
- Obesity Screening and Counseling for adults and children: Obesity screening and counseling by primary care providers in a Physicians’ offices. Those who screen for a body mass index meeting a specific threshold may receive intensive behavioral interventions to promote improvement in weight status;
- Osteoporosis screening in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors;
- Phenylketonuria screening in newborns
- Preeclampsia prevention with the use of low-dose aspirin as a preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia;
- Prostate screening for the early detection of prostate cancer in men over age 50, and in men over age 40 who are in high-risk categories;
- Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care, and Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks gestation unless the biological father is known to be Rh(D)-negative;
- Screening for gestational diabetes in pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
- Screening and counseling for human immune-deficiency virus infection for all sexually active women;
- Sexually transmitted infections counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections;
- Skin cancer behavioral counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin, to educate about minimizing their exposure to ultraviolet radiation to reduce the risk for skin cancer;
- Statin preventive medication for adults ages 40-75 with no history of cardiovascular disease for the prevention of cardiovascular disease events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.
- Syphilis screening for pregnant women and any person at increased risk for infection;

- Tobacco use screening and interventions including tobacco cessation programs for adults, children and adolescents. Smoking Cessation – any charges for the use of Colorado's Quitline services to aid in quitting tobacco use; this would include up to five (5) cessation coaching sessions and Nicotine Replacement Therapy (NRT) medications. **You can access Quitline by calling 1-800-QUIT-NOW/1-800-784-8669.**
- Tuberculosis screening for latent tuberculosis infection in populations at increased risk.
- Visual screening for all children at least once between the ages of 3 and 5 years to detect the presence of amblyopia or its risk factors.
- Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care.
- Any other preventive services included in the A or B recommendations of the task force for the particular preventive health care service or as required by state or federal law. For a complete list of Preventive Care services, please visit the U.S. Preventive Services Task Force website: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

Note: *If the Covered Person receives the same preventive screening more than once in a given calendar year, Benefits for the additional screening are payable under the Lab, X-Ray and Diagnostics – Outpatient benefit and are subject to any applicable Annual Deductible, Copayment, or Coinsurance.*

Private Duty Nursing
Covered Health Services under this section include Medically Necessary nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting.

Prosthetic Devices
Covered Health Services under this section include external prosthetic devices that replace a limb or a body part, limited to:
- Prosthetics will be covered in accordance with Medicare guidelines and criteria.
- Bionic, myoelectric, microprocessor-controlled, and computerized Prosthetics are covered in accordance with Medicare guidelines and criteria.
- Artificial face, eyes, ears, and noses.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet Your functional needs, coverage is available only for the prosthetic device that meets the minimum specifications for Your needs. If You purchase a prosthetic device that exceeds these minimum specifications, We will pay only the amount that We would have paid for the prosthetic that meets the minimum specifications, and You will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.
Coverage is available for repairs and replacement, except that:
- There are no Benefits for repairs due to misuse.
- There are no Benefits for replacement due to misuse or loss.

<u>Implanted Medical Devices</u>
Implanted medical devices must be Pre-Authorized by Us and must be ordered by an In-Network Provider. These devices include but are not limited to pacemakers, artificial hip joints, and cochlear implants. Coverage consists of permanent or temporary internal aids and supports for defective body parts. The Plan will also cover the cost for repairs or maintenance of covered appliances.

Radiation Services - Outpatient
Covered Health Services under this section includes radiation oncology treatment received on an outpatient basis at a Hospital or Alternate Facility.

Covered Health Services include medical education services that are provided on an outpatient

basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease that requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.

Physician services for anesthesiologists, pathologists, and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services* provision of the *Benefits/Coverages (What is Covered) section of this Policy*.

Rehabilitative and Habilitative Services – Outpatient Therapy

Rehabilitative Services – Outpatient Therapy

Covered Health Services under this section include short-term outpatient Rehabilitative Services, limited to 20 visits per calendar year for each service:

- Physical therapy.
- Occupational therapy.
- Speech therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider and include services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Note: *We will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders.*

Habilitative Services – Outpatient Therapy

Covered Health Services under this section include short-term outpatient Habilitative Services, limited to 20 visits per calendar year for each service:

- Physical therapy.
- Occupational therapy.
- Speech therapy.

Reconstructive Procedures

Covered Health Services under this section include reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures that are associated with an Injury, Sickness, or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness, or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Statement of Rights under the Women's Cancer Rights Act of 1998

If You have had or are going to have a mastectomy, You may be entitled to certain Benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related Benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These Benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical Benefits provided under this Plan. (See the "Schedule of Benefits (Who Pays What)" for details.) If You would like more information on WHCRA Benefits, call us at the number listed in Section 3 of this *Policy* or on the back of Your Identification Card.

Scopic Procedures – Outpatient Diagnostic and Therapeutic
Covered Health Services under this section include diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

Diagnostic scopic procedures are those for visualization, biopsy, and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Note: *Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under Surgery – Outpatient provision of the Benefits/Coverages (What is Covered) section of this Policy. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, and hysteroscopy*.

When these services are performed for preventive screening purposes, coverage is described under *Preventive Care Services* provision of the *Benefits/Coverages (What is Covered) section of this Policy*.

Skilled Nursing Facility
Covered Health Services under this section include charges incurred while confined in a Skilled Nursing Facility. Coverage is available for:
- Physician and non-physician services, including but not limited to charges for anesthesiologists, consulting Physicians, pathologists, and radiologists.
- Medically Necessary supplies
- Room and board in a Semi-private Room (a room with two or more beds).
- Skilled care, skilled nursing, skilled teaching, and skilled rehabilitation services when **all** of the following are true:
  - Services are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
  - Services are ordered by a Physician.
  - Services are not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair.
  - Services require clinical training in order to be delivered safely and effectively.

We will determine if coverage is available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Please note that coverage is available only if both of the following are true:
- If the initial confinement in a Skilled Nursing Facility was or will be a cost-effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily for Custodial Care.

Coverage is limited to one hundred (100) days per calendar year.

Sleep Studies
Covered Health Services under this section include sleep studies and related services when performed at home including auto-titration.

Sleep studies performed in a Hospital or Alternate Facility are covered when Medically Necessary. These charges include Physician services, interpretation of the sleep study and the sleep lab.

Surgery – Outpatient
Covered Health Services under this section include surgery and related services for a Sickness, Injury, or condition that are received on an outpatient basis at a Hospital or Alternate Facility. For the purposes of this benefit, congenital heart disease is considered a Sickness.
Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, and hysteroscopy.

Benefits under this section include the facility charge and the charge for supplies and equipment and Physician services for anesthesiologists, pathologists, and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services* provision of the *Benefits/Coverages (What is Covered) section of this Policy*.)

Temporomandibular Joint Disorder (TMJ)
Covered Health Services under this section include Medically Necessary services for the treatment of TMJ, including diagnostic X-rays, lab testing, physical therapy, and surgery.

Transplantation Services
Covered Health Services under this section include organ and tissue transplants when ordered by a Physician. Coverage is available for transplants when the transplant meets the definition of a Covered Health Service and is not an Experimental, Investigational, or Unproven Service. Services may be required to be rendered at a Center of Excellence facility.

Examples of transplants for which coverage is available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel, and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under this Policy.

Travel Expenses
Covered Services under this benefit include reimbursement for travel expenses primarily related to Transplantation Services, including meals and lodging when it is necessary for a Covered Person to receive care from a designated Center of Excellence facility that is located more than 100 miles from the Covered Person's home.

Travel expenses are also reimbursable if We direct You for treatment at a facility more than 100 miles from Your home because treatment is not available In-Network, within Our Service Area.

Travel reimbursement amounts are based on the federal CONUS rate for the city in which services are received.

Travel reimbursement is also available for donor costs related to transplantation services based on the federal CONUS rate for the city in which services are received.

Urgent Care Center Services
Covered Health Services under this section include services received at an Urgent Care Center for an unexpected episode of Sickness or Injury including the onset of acute or severe symptoms which requires treatment that if postponed would result in the deterioration of the health condition. Urgent Care conditions include, but are not limited to ear ache, sore throat, and fever.

When services to treat an urgent health care need are received in a Physician's office instead of at an Urgent Care Center, benefits will be paid in accordance with the *Physician's Services for Sickness and Injury* provision of the *Benefits/Coverages (What is Covered) section of this Policy*.

Wigs
Covered Health Services under this section includes coverage for one (1) wig per calendar year, up to $500.

Section 8 - Limitations/Exclusions (What is Not Covered)

How We Use Headings in this Section

To help You find specific exclusions more easily, We use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit, or expand an exclusion. All exclusions in this section apply to You.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Benefits/Coverages (What is Covered) section of this Policy,* those limits are stated in the corresponding category in the *Schedule of Benefits (Who Pays What) section of this Policy*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits (Who Pays What) section of this Policy* under the heading *Benefit Limits*. Please review all limits carefully, as We will not pay Benefits for any of the services, treatments, items, or supplies that exceed these Benefit limits.

Benefit Exclusions

We will not pay Benefits for any of the services, treatments, items, or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for Your condition.

The services, treatments, items, or supplies listed in this section are not Covered Health Services, unless provided for in the *Benefits/Coverages (What is Covered) section of this Policy*.

Please note that in listing services or examples, when We say, "this includes," it is not Our intent to limit the description to that specific list. When We do intend to limit a list of services or examples, We state specifically that the list "is limited to."

Alternative Treatments

Health care services excluded under this provision include the following:

- Acupuncture
- Acupressure
- Aromatherapy
- Hydrotherapy
- Hypnotism
- Massage therapy
- Naturopathy
- Rolfing
- Art therapy, music therapy, dance therapy, horseback therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.

Custodial or Domiciliary Care

Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting and taking medicine.

Dental Care

Dental care, except as defined under Section 7, Pediatric Dental Care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and

anesthesia) is not covered.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive medications.
- The direct treatment of cancer or cleft lip or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded except as defined under Section 7, Pediatric Dental Care.

Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums is excluded, except as defined under Section 7, Pediatric Dental Care. Examples include:

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

Dental implants, bone grafts, and other implant-related procedures. This exclusion does not apply to accident-related dental services or for services related to the treatment of cleft lip and cleft palate.

Dental braces (orthodontics) are not covered, except as defined under Section 7, Pediatric Dental Care, or when Medically Necessary.

Treatment of congenitally missing, mal-positioned, or supernumerary teeth, even if part of a Congenital Anomaly are excluded.

Dentures, Bridges, Crowns and other dental prostheses are excluded.

This exclusion does not apply to dental services required for the direct treatment of a medical condition such as treatment for cleft lip or cleft palate for which Benefits are described in Section 7; or for accident-related dental services received within 12 months from the date of the accident or injury. Dental services received more than 12 months after the accident or injury are not covered.

Devices, Appliances

Health care services excluded under this provision include the following devices or appliances even when prescribed by a Physician.

- Devices used specifically as safety items or to affect performance in sports-related activities
- Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics (except for diabetic shoes), cranial banding and some types of braces, including over-the-counter orthotic braces.
- Enuresis alarm
- Blood Pressure cuff/monitor
- Home coagulation testing equipment
- Non-Wearable external defibrillator
- Trusses
- Ultrasonic nebulizers
- Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics
- Oral appliances
- Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes.

Directed Blood Donations
Directed Blood Donations are excluded from coverage.

Employer or Governmental Responsibility
Financial responsibility for services that an employer or a government agency is required to provide by law.

Experimental, Investigational, or Unproven Services
Health care services excluded under this provision include Experimental, Investigational, and Unproven Services and all related services. The fact that an Experimental, Investigational, or Unproven Service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational, or Unproven in the treatment of that particular condition. This exclusion does not apply to a prescribed drug if:

- The drug has been approved by the FDA as an "investigational new drug for treatment use"; or
- If it is a drug classified by the *National Cancer Institute* as a Group C cancer drug when used for treatment of a "life-threatening disease" as that term is defined in FDA regulations.

This exclusion does not apply to Covered Health Services provided during a clinical trial as described under the *Benefits/Coverage (What is Covered) section of this Policy*.

Foot Care
Health care services excluded under this provision include the following:

- Routine foot care, such as cutting or removal of corns and calluses, nail trimming, cutting, or debriding, except when performed specifically for the purpose of treating pain related to functional limitations
- Hygienic and preventive maintenance foot care. Examples include:
  - Cleaning and soaking the feet
  - Applying skin creams in order to maintain skin tone
- Shoes
- Treatment of flat feet

This exclusion does not apply to foot care services rendered in relation to diabetes for which coverage is provided as described under the Benefits/Coverage (What is Covered) section of this Policy.

Genetic Testing
Genetic testing is excluded unless it is Medically Necessary for the identification of genetically-linked inheritable disease. Please refer to Section 7, Genetic Testing and Preventive and Wellness Services for information about Genetic Testing that is covered by the plan.

Hearing Aids for Adults
Services excluded under this section are the purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA), and all other hearing assistive devices. This does not apply to hearing aids for Hearing Aids for Minor Children under age 18 as described under *Benefits/Coverage (What is Covered)* section of this *Policy*.

Infertility/Reproduction
Health care services excluded under this provision include the following:

- Services to reverse voluntary, surgically induced infertility;
- All Services and supplies (other than artificial insemination) related to conception by artificial means. This means prescription drugs related to such services such as, but not limited to in vitro fertilization, ovum transplants, gamete intra fallopian transfer and zygote intra fallopian transfer are not covered. These exclusions apply to fertile as well as infertile individuals or couples.
- Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.

- Surrogate parenting, donor eggs, donor sperm, and host uterus, except when the surrogate is insured under this plan;
- Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue, and ovarian tissue;
- Fetal reduction surgery;
- Genetic testing of embryos pre or post implantation;
- Medications used to treat infertility or impotence.

Medical Supplies and Equipment
Health care services excluded under this provision include prescribed or non-prescribed medical supplies and disposable supplies, unless provided through Home Health Care. Examples include:
- Elastic stockings
- Ace bandages
- Antiseptics
- Gauze and dressings
- Urinary catheters
- Tubings and masks
- Deodorants
- Filters
- Lubricants
- Tape
- Appliance cleaners
- Adhesive
- Adhesive remover

Neurobiological Disorders
Health care services excluded under this provision include services such as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition or services that is school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills, and primary communication disorders as defined in the current edition of Diagnostic and Statistical Manual of the American Psychiatric Association and which are not part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by Us.

This exclusion does not apply to treatments related to Autism Spectrum Disorder, Early Childhood Invention Services, and Habilitative Services.

Nutrition
Health care services excluded under this provision include the following
- Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
  - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
  - There exists a knowledge deficit regarding the disease that requires the intervention of a trained health professional.
- Enteral feedings, even if the sole source of nutrition except for the first 31 days of life, and except for the treatment of Phenylketonuria (PKU) as described in the Covered Health Services section.
- Infant formula and donor breast milk.
- Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Other Services
Health care services excluded under this provision include the following:
- Health services for treatment of military service-related disabilities, when You are legally entitled to other coverage and facilities are reasonably available to You.
- Health services while on active military duty.
- Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements.

Personal Care, Comfort, or Convenience
Items excluded under this provision include the following:
- Television
- Telephone
- Beauty/barber services
- Guest service
- Supplies, equipment, and similar incidental services and supplies for personal comfort Examples include:
  - Air conditioners, air purifiers and filters, dehumidifiers.
  - Batteries and battery chargers.
  - Car seats.
  - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
  - Electric scooters.
  - Exercise equipment.
  - Home modifications such as elevators, handrails, and ramps.
  - Hot tubs.
  - Humidifiers.
  - Jacuzzis/ Whirlpools/ Saunas.
  - Mattresses.
  - Medical alert systems.
  - Motorized beds.
  - Music devices.
  - Personal computers.
  - Pillows.
  - Power-operated vehicles.
  - Radios.
  - Safety equipment.
  - Speech generating devices.
  - Stair lifts and stair glides.
  - Strollers.
  - Treadmills.
  - Vehicle modifications such as van lifts.
  - Video players.

Physical Appearance
Health care services excluded under this provision include the following:
- Cosmetic Procedures. **See the definition in the *Definitions* section**. Examples include:
  - Pharmacological regimens, nutritional procedures, or treatments.
  - Scar or tattoo removal or revision procedures (such as salabrasion, laser removal, chemosurgery, and other such skin abrasion procedures).
  - Skin abrasion procedures performed as a treatment for acne.
  - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
  - Treatment for skin wrinkles or any treatment to improve the appearance of the skin, including blepharoplasty or eyelid surgery.
  - Treatment for spider veins or varicose veins. This includes, but is not limited to vein stripping, laser procedures or surgery.
  - Fat injections or fat grafting.
  - Hair removal or replacement by any means.
- Replacement of an existing breast implant if the earlier breast implant was performed as a

Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.

- Treatment of benign gynecomastia (abnormal breast enlargement in males).
- Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery that is required to treat a physiologic functional impairment or which is required by the *Women's Health and Cancer Right's Act of 1998* and described under the *Benefits/Coverages (What is Covered) section of this Policy*.
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
- Wigs, toupees, hair transplants or hair weaving for male pattern baldness.

Physician Assisted Suicide
Services provided by a Physician or medical professional to assist a member in ending his or her life are excluded from coverage under this plan.

Prescription Drugs
Health care services excluded under this provision include the following:

- Prescription Drug Products obtained through a Non-Network Pharmacy.
- Non-Prescription Medications (medications that do not require a prescription), unless specifically included as covered elsewhere in this document, or mandated by Law.
- Medications for which the condition or services are excluded under your Schedule of Benefits or the Policy.
- Medications not approved by the FDA
- Early prescription refills to replace a lost, stolen, or destroyed prescription or prescription supplies, or exceeding the Day's Supply Limit, Quantity or Supply Limits.
- Medications prescribed solely for cosmetic purposes.
- Human Growth Hormone prescribed to adults for any reason.
- Medications available as bulk powder only.
- Medications which are labeled or deemed Investigational or Experimental, including regimens that are unproven.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Prescription Drug Products furnished by local, state, or federal government. Any Prescription Drug Product to the extent payment or Benefits is provided or available from the local, state, or federal government (for example, Medicare) whether or not payment or Benefits are received, except as otherwise provided by law.
- Prescription Drug Products for any condition, Injury, Sickness, or Mental Illness arising out of, or in the course of, employment for which Benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such Benefits is made or payment or Benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Durable Medical Equipment.
- Prescribed and non-prescribed outpatient supplies, other than diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins except as described under the Preventive and Wellness Services of the Benefits/Coverage (What is Covered) section of this Policy.
- Medication prescribed for the treatment of hair loss
- Off-label use of medications unless required by Law, then allowed in accordance with Law.
- Biological sera, blood, blood products or plasma.
- Oxygen, Medical Devices or Equipment, unless specifically listed as covered.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms that We determine do not meet the definition of a Covered Health Service.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except for Medical Foods prescribed for the treatment of Inherited Enzymatic Disorders.

- Medications used to treat Erectile Dysfunction.
- Topical medications for the treatment of onychomycosis of the toenails.
- Allergy serum.
- Prescription drugs with a non-prescription equivalent except as described under the Preventive and Wellness Services of the Benefits/Coverage (What is Covered) section of this Policy.
- Unit-dose or re-packaged medications, or costs related to re-packaging of available covered medications.
- Marijuana, including but not limited to medical marijuana for any reason.

Prescription Drugs Limitations

Health care services limited under this provision include the following:

- 30-day supply of covered medications per prescription is allowed, other quantity limits may be applied to claims.
- All medications are subject to our utilization review process and quantity limits. New prescriptions to treat certain chronic conditions are limited to a 30-day supply. In addition, certain medications may be subject to any quantity limits applied as part of our trial program. A 90-day supply will be covered and dispensed only at pharmacies that participate in our extended day supply program. No more than a 30-day supply of Specialty Medications will be covered and dispensed at a time.
- If a member requests a brand medication when there is a generic equivalent, the brand medication will be covered up to the charge that would apply to the generic medication, minus any required copayment. If a physician requests that a brand medication be dispensed as written, the medication will be paid at the non-formulary (Tier 4) benefit.
- The member copayment for a medication will not exceed the cost of the medication.
- If a member copayment is required, you must pay one member copayment for each 30-day supply, or portion thereof, except for Mail Order Medications.

Procedures and Treatments

Health care services excluded under this provision include the following:

- Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.
- Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
- Psychosurgery.
- Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- Speech therapy except as required for habilitative treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorders.
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or Medically Necessary treatment of Temporomandibular Joint Disorder, dislocation, tumors, orthognathic surgery, jaw alignment, or cancer.
- Remote surgical neuromonitoring.

Providers

- Services performed by a provider who is a family member by birth or marriage. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with Your same legal residence.
- Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a freestanding or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
  - Has not been actively involved in Your medical care prior to ordering the service, or
  - Is not actively involved in Your medical care after the service is received.

This exclusion does not apply to mammography.

Services Received Outside of Your Policy Coverage Period
Health services received prior to your Policy effective date, or after the date Your coverage ends are excluded under this provision. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date Your coverage under this *Policy* ended.

Services Rendered by a Non-Participating Provider
Benefits and services from Non-Network providers, except in the case of a medical emergency, or when Pre-authorized by Us are excluded from coverage.

Services that are not Medically Necessary
Services that are not Medically Necessary are excluded under this provision.

Transplantation Services
Health care services excluded under this provision include the following:
- Health services for organ and tissue transplants, except those described under this Policy;
- Health services connected with the removal of an organ or tissue from You for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under this Policy.)
- Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

Travel
Health care services excluded under this provision include the following:
- Non-Network Health services provided in a foreign country, except as required for Emergency Health Services.
- Travel or transportation expenses, even though prescribed by a Physician, except as described in the *Transplant* provision of the *Benefits/Coverage (What is Covered) section of this Policy*.

Types of Care
Health care services excluded under this provision include the following:
- Multi-disciplinary pain management programs provided on an inpatient basis
- Respite care, except as covered under the *Hospice Care* provision of the *Benefits/Coverages (What is Covered) section of this Policy*
- Rest cures
- Services of personal care attendants
- Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work)

Vision Services
Health care services excluded under this provision include the following:
- Purchase cost and fitting charge for eyeglasses, frames, or contact lenses, except as covered under Pediatric Vision Services.
- Adult eye exams except when Medically Necessary and performed by an Ophthalmologist for medical conditions of the eye, not including keratoconus.
- Implantable devices used to correct a refractive error (such as Intacs corneal implants).
- Eye exercise therapy.
- Surgery that is intended to allow You to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

All Other Exclusions
Items excluded under this provision include the following:
- Administrative services
- Aids or devices that assist with non-verbal communications.
- Ambulance services that are not Medically Necessary.
- Autopsy, except as may be reasonably required by Us at Our own expense.
- Charges for services provided by a stand-by Physician.
- Charges in excess of the Allowed Amount or in excess of any specified limitation.

- Charges unsupported by medical records.
- Claims received by us after 12 months from the date service was rendered, except in the event of legal incapacity or as required by law.
- Continuous glucose monitoring for patients who are not Type I diabetics
- Court-ordered testing, except for mental health or substance abuse testing or treatment as required by state law.
- Free Care.
- Gym fees or memberships.
- Health services and supplies that do not meet the definition of a *Covered Health Service* - see the *Definitions* section.
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
- Inpatient stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- Long-term (more than 30 days) storage of products such as cryopreservation of tissue, blood, and blood products.
- Medical services and procedures that are not legal.
- Missed and canceled appointments.
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under this Policy when:
  - Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage, or adoption.
  - Related to judicial or administrative proceedings or orders unless Medically Necessary and for covered services under this policy.
  - Conducted for purposes of medical research.
- Required to obtain or maintain a license of any type
- Preventive Care services rendered by an out of network provider or at an out of network facility.
- Services performed as a result of complications related to or attributable to services that are specifically excluded from coverage under this *Policy*.
- Services received because of participation in an insurrection, rebellion or riot.
- Services received as a result of a commission of, or an attempt to commit a felony (whether or not charged) or as a result of being engaged in an illegal act or occupation.
- Virtual colonoscopy including CT colonography and capsule endoscopy and colonography
- Virtual coronary angiography and coronary calcium scans
- Voluntary, elective abortions and any related services, drugs or supplies are excluded. Exceptions are made when the abortion is deemed Medically Necessary including to preserve the life or health of the mother if the pregnancy continues to term; or when the pregnancy is the result of an act of rape or incest; or when a likely fatal or long-term morbidity is identified in the fetus during testing; or treatment of complications following a Medically Necessary abortion.

Section 9 - Member Payment Responsibility

Your Responsibilities

Show Your ID Card
Show Your identification (ID) card every time You receive health care services. If You do not show Your ID card, Your provider may not bill Us for Your services. Any delay may cause You to be unable to collect Benefits owed to You.

You must show Your ID Card at the pharmacy when You receive prescription drugs. The information on Your ID Card helps the pharmacy verify that You are covered. It also helps determine the cost of Your medications. If the pharmacy does not have the information from Your ID Card, they will not be able to provide Your medication at Your plan benefits. If You do not show Your ID Card, You may pay full price for Your medication.

It is important that You make sure Your provider has the correct billing information on file for Your plan.

Pay Your Share
You may have a Deductible, Copayment, and/or Coinsurance amounts to meet. The amounts are listed in the *Schedule of Benefits (Who Pays What) section*. These are costs You must pay for most Covered Health Services. They are due when you get care or when You are billed by the Provider. You will need to work with Your provider to determine how to meet Your cost-sharing requirements.

You will be responsible for charges that exceed Our Allowable Amount if You receive care from a Non-Network Provider. The Allowable Amount is the amount negotiated by Us with the Non-Network Provider, or up to 160% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, whichever is less.

Pay the Cost of Excluded Services
You must pay for services that are not covered. These are called Excluded Services. Please review the *Limitations/Exclusions (What is Not Covere*d) section of this *Policy* so you know what is not covered.

File Claims with Complete and Accurate Information
When You receive health care services from a Non-Network Provider, You must send Us the information that We need to review Your claim. If We do not have all of the information that We need, We cannot consider Your claim. *See the Claims Procedures (How to File a Claim) section of this Policy.*

Our Responsibilities

Pay for Our Portion of the Cost of Covered Health Services
We pay for the Covered Health Services as shown in the *Schedule of Benefits (Who Pays What)* section. There is more information in the *What is Covered* section. Not all health care services are covered by the plan. Services considered Medically Necessary may still not be covered by the Plan or certain limitations may also apply. Read the *Limitations/Exclusions (What is Not Covered) section* to see Your plan's limitations and exclusions.

Pay Network Providers
Your Network Providers must file claims to Us for payment. When You receive health services from Network Providers, You do not have to send Us a claim.

Pay for Covered Health Services Provided by Non-Network Providers
We will only pay for Benefits after We receive a request for payment that includes all of the required

information. You or Your Provider must send Us the information that We need to review Your claim. If We do not have all of the information that We need, We cannot consider Your claim. *See the Claims Procedures (How to File a Claim) section of this Policy.*

Offer Health Education Services to You

As a member of Our Plan, we may send You information about other services. We may send You information about disease management, health education, and patient advocacy. It is Your decision if you want to participate in these programs. We recommend that You discuss them with Your Physician.

Section 10 - Claims Procedure (How to File a Claim)

If You Receive Covered Health Services from a Network Provider

We pay Providers for Your Covered Health Services. You are responsible for meeting Your Annual Deductible and for paying any required Copayments and Coinsurance at the time of service, or when You receive a bill from the provider.

BENEFITS ARE NOT AVAILABLE WHEN YOU USE A NON-NETWORK PROVIDER, EXCEPT FOR EMERGENCY HEALTH SERVICES OR SERVICES RECEIVED FROM AN NON-NETWORK PROVIDER WORKING IN A NETWORK FACILITY.

Assignment of Benefits

If a provider or other party receives written permission from a Member to receive payment for services directly from the Us, We will honor the agreement and pay the Provider.

Required Claim Information

When You request payment of Benefits from Us, You must provide Us with all of the following information:

- The Subscriber's name and address.
- The patient's name and date of birth.
- The ID number stated on Your ID card.
- The name, address and Tax ID, and NPI number of the provider of the service(s).
- The date that services were received.
- The name and address of any ordering/referring Physician.
- The ICD-10 diagnosis code from the Physician.
- An itemized bill from Your provider that includes the Current Procedural Terminology (CPT) codes for each charge.
- The date the Injury or Sickness began.
- A statement indicating either that You are, or You are not, enrolled for coverage under any other health insurance plan or program. If You are enrolled for other coverage You must provide the name of the other carrier(s) and your ID number for the other coverage.

Notice of Claim or Proof of Loss

Written notice of claim or proof of loss must be furnished to Us within twenty (20) days after the occurrence of any loss covered by the policy, or as soon thereafter as is reasonably possible. Electronic submission of the notice of claim or proof of loss is acceptable as submission on paper. Failure to furnish such notice of claim or proof of loss within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time. In no event, except in the absence of legal capacity of the claimant, shall proof be furnished later than one (1) year from the date of loss.

There is no paperwork for claims for services from Network Providers. You will need to show Your ID card and pay any required copayment; Your Network 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

When a request for a claim form or the notice of a claim is provided to Us, We will provide the claimant or policyholder the claim forms required for filing. If the claimant does not receive these claim forms within 15 days after the Plan receives notice of claim or the request for a claim form,

the claimant will be considered to meet the proof of loss requirement of this Policy. Foreign claims must be translated in U.S. currency prior to being submitted to the Plan for payment.

You may find the required claim forms on our website at www.brighthealthplan.com or by calling Customer Service at the number listed on Your identification card.

Payment of Claims Upon Death

Upon the death of a Covered Person, claims will be payable to the Covered Person's estate. If the Provider is a Network Provider, claims payments will be made to the Provider.

Finalization of Claims

When all required information is submitted, We will make an initial benefit determination on electronic clean claims within 30 calendar days of receipt. For clean, paper claims, We will make an initial benefit determination within 45 calendar days of receipt. If the resolution of a claim requires additional information, We shall, within 30 calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by Us within 30 calendar days after receipt of such request. We may deny a claim if We request additional information and information is not provided to us in a timely manner. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the Us within 30 days for electronic submission or 45 days for paper submission. Absent fraud, all claims will be paid, denied or settled within 90 days.

Timely Filing

Claims for Covered Health Services from a Non-Network or Non-Participating Provider must be submitted to Us within one year (365 days) from the date of service. If your Provider does not file a claim for You, You are responsible for filing the claim within the one-year deadline. Claims submitted after the deadline are not eligible for benefit payment or reimbursement. If a claim is returned to You because We need additional information, You must resubmit it with the information requested within 30 days of receipt of the request. Claims can be submitted to Us at:

Claim Submissions and Correspondence Address:

Bright Health Insurance Company
P.O. Box 16275
Reading, PA 19612

Section 11 - General Policy Provisions

Your Relationship with Us

In order to make choices about Your health care coverage and treatment, We believe that it is important for You to understand how We interact with your providers.

- We do not decide what care You need or will receive. You and Your Physician make those decisions.
- We communicate to You decisions about whether this plan will cover or pay for the health care that You may receive. The plan pays for Covered Health Services, which are more fully described in this *Policy*.
- The plan may not pay for all treatments You or Your Physician may believe are necessary. If the plan does not pay, You will be responsible for the cost.

Our Relationship with Providers

The relationships between Us and Network Providers are solely contractual relationships. Network Providers are not Our agents or employees. Neither We nor any of Our employees are agents or employees of Network Providers We do not provide health care services or supplies, nor do We practice medicine. Instead, We arrange for health care providers to participate in a Network and We pay Benefits. Network Providers are independent practitioners who run their own offices and facilities. We are not liable for any act or omission of any provider.

Your Relationship with Providers

The relationship between You and any provider, is that of provider and patient.

- You are responsible for choosing Your own provider.
- You are responsible for paying, directly to Your provider, any amount identified as Your responsibility, including Copayments, Coinsurance, any Annual Deductible, and any amount that exceeds the Allowed Amount.
- You are responsible for paying, directly to Your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating You is right for You. This includes Network Providers You choose and providers to whom You have been referred.
- You must decide with Your provider what care You should receive.
- Your provider is solely responsible for the quality of the services provided to You.

Incentives to Providers

We pay Network Providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of quality health care in a cost efficient and effective manner. These financial incentives are not intended to affect Your access to health care. An example of financial incentives for Network Providers is bonuses for performance based on factors that may include quality, Your satisfaction, and/or cost-effectiveness.

We use various payment methods to pay specific Network Providers. From time to time, the payment method may change. If You have questions about whether Your Network Provider's contract with Us includes any financial incentives, We encourage You to discuss those questions with Your provider.

Incentives to You

We may offer You incentives to encourage You to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is Yours alone but We recommend that You discuss participating in such programs with Your Physician. Contact Us if You have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to You in Your home or in a Physician's office, or at a Hospital, or Alternate Facility. This includes rebates for those drugs administered to You before You meet any applicable Annual Deductible. We do not pass these rebates on to You, nor are they applied to any Annual Deductible or taken into account in determining Your Copayments or Coinsurance.

Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under this Policy.
- Interpret the other terms, conditions, limitations, and exclusions, including this *Policy* which includes the *Schedule of Benefits* and any *Amendments*.
- Make factual determinations related to this Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of this Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, We may, in Our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that We do so in any particular case shall not in any way be deemed to require Us to do so in other cases, similar or not.

Evaluation of New Technology

Coverage for new technology that is experimental, investigational or not deemed Medically Necessary is excluded from coverage.

We will evaluate the utilization of new technology as related to medical and behavioral health procedures, pharmaceuticals and devices.

Information from published peer-reviewed Scientific Evidence, governmental regulatory bodies and Specialists and professionals who have relevant expertise with the new technology is reviewed against technology or intervention assessment criteria, which must be met to merit consideration as a covered benefit.

Administrative Services

We may, in Our sole discretion, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time at Our sole discretion. We are not required to give You prior notice of any such change, nor are We required to obtain Your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Information and Records

By accepting Benefits under this Policy, You authorize and direct any person or institution that has provided services to You to furnish Us with all information or copies of records relating to the services provided to You. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We may use Your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that You may find valuable, and as otherwise permitted or required by law. We may request additional information from You to decide Your claim for Benefits. We will keep this information confidential. We may also use Your de-identified data for commercial purposes, including research, as permitted by law. More detail about how We may use or disclose Your information is found in Our *Notice of Privacy Practices*.

We have the right to release any and all records concerning health care services, which are necessary to implement or administer the terms of this Policy, for appropriate medical review or quality assessment, or as We are required to do by law or regulation. During and after the term of this Policy, We and Our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to Our Notice of Privacy Practices.

For complete copies of Your medical records or billing statements We recommend that You contact Your health care provider. Providers may charge You reasonable fees to cover their costs for providing records or completing requested forms.

If You request medical forms or records from Us, We also may charge You reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, We will designate other persons or entities to request records or information from or related to You, and to release those records as necessary. Our designees have the same rights to this information as We have.

Extension of Benefits

If You are hospitalized on the end date of your Policy with Us and Your Policy is not being terminated for non-payment, benefits will be extended beyond your termination date until You are discharged from the hospital. We will pay for Covered Health Services received during that hospitalization if premiums were paid through Your termination date.

Examination and Autopsy

We have the right at Our expense, to request an examination of Covered Persons by a Provider of Our choice. Upon the death of a Covered Person, We may request an autopsy, unless prohibited by law.

Integration of Medicare Benefits

Benefits under this Plan will pay secondary to Medicare only. We will not coordinate benefits with other plans. We will not provide benefits that duplicate any benefits You would be entitled to receive under Medicare.

If You have Medicare, Your Medicare coverage will not affect the Covered Services covered under this Policy, except as follows:

- Your Medicare coverage will be applied first (primary) to any services covered by both Medicare and this Policy.
- If You receive a service that is covered both by Medicare and this Policy, we will allow no more than the amount allowed by Medicare for the same Covered Health Service when calculating benefits payable under the terms of this Policy. All benefits payable under this Policy are subject the applicable deductible, copayment and/or coinsurance for the Covered Health Service as outlined in the Schedule of Benefits.

Eligibility for Medicare

If You or a Dependent are entitled to and enrolled in Medicare or if a Member of this Policy becomes eligible for and enrolled in Medicare by reason of age, disability, End Stage Renal Disease or any other eligibility category, We will consider what Medicare will pay to the extent permitted by law. This means that We will determine coverage and payment available to the Member after subtracting the amounts that Medicare will pay.

Workers' Compensation

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by Workers' Compensation insurance. We will not pay for services and supplies related to an Illness or Injury resulting from Your course of employment. Such Illnesses or Injuries are generally covered under such laws as:

- Occupational disease laws;

- Employer's liability policies;
- Municipal, state or federal law;
- The Workers' Compensation Act.

You must pursue Your rights under the Workers' Compensation Act or any other laws that may apply to Your situation. This includes filing an appeal with the Colorado Industrial Commission, if necessary.

Your failure to (a) file a claim within the filing period allowed by the applicable law; (b) obtain authorization for care, as may be required by Your employer's workers' compensation insurance; or (c) comply with any other provisions of the above laws, will not qualify You to receive coverage for work-related Injury or Illness from Us.

Your employer's failure to carry the workers' compensation insurance will not qualify You to receive coverage for a work-related Injury or Illness from Us.

There are a limited number of exceptions under which We may pay for services and supplies needed because of work-related Injury or Illness:

- If You have an appeal pending in front of the Colorado Industrial Commission. We may pay claims for certain services if You sign an agreement to repay The Plan for 100 percent of services paid by Us when the appeal is decided in Your favor.
- If You qualify under Colorado law to reject workers' compensation coverage as an owner and officer of Your business. We reserve the right to request documentation to substantiate Your lawful rejection of coverage.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand, or right. Subrogation usually means bringing suit against a person or entity that has injured You. If You choose not to file a claim against the person or entity that has injured You, We will be subrogated to and will succeed to Your right of recovery under any legal theory of any type for the reasonable value of any services and Benefits We provided to You, from any and all of the following.

If You file a claim against the person or entity that has injured You, You are obligated to reimburse Us for the reasonable value of Our services to You once You have been fully compensated for the costs You incur related to Your Injury from any or all of the following listed below.

- Third parties, including any person alleged to have caused You to suffer injuries or expenses.
- Any person or entity who is or may be obligated to provide Benefits or payments to You, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.
- These third parties and persons or entities are collectively referred to as "Third Parties".

You agree as follows:

- That You will cooperate with Us in protecting Our right to reimbursement, including, but not limited to:
  - providing any relevant information requested by Us,
  - signing and/or delivering such documents as We or Our agents reasonably request to secure the reimbursement claim,
  - responding to requests for information about any accident or injuries, and making court appearances, and
  - obtaining Our consent or Our agent’s consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the instigation of legal action against You.
- That We have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- That Benefits paid by Us may also be considered to be Benefits advanced.
- That You will seek Our approval of any settlement that does not fully compensate or reimburse You and Us and You will not do anything to prejudice Our rights under this provision.
- That, if You do not file a claim, You will assign to Us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits We provided, plus reasonable costs of collection.
- That We may, if You do not file a claim, take necessary and appropriate action to preserve Our rights under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay You part of any recovery We might obtain.
- That We will not be obligated in any way to pursue this right independently or on Your behalf.
- That in the case of Your wrongful death, the provisions of this section will apply to Your estate, the personal representative of Your estate, and Your heirs.
- That the provisions of this section apply to the parents, guardian, or other representative of a Child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a Child's Injury, the terms of this reimbursement clause shall apply to that claim.

Refund of Overpayments

If We overpay Benefits for expenses incurred on account of a Covered Person, the person or entity that was paid must refund to Us:

- All or some of the payment We made that exceeded the Benefits under this Policy.
- All or some of the payment that was made in error.

The refund equals the amount We paid in excess of the amount that We should have paid under this Policy. If the refund is due from another person or organization, the Covered Person agrees to help Us get the refund when requested.

Limitation of Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished. By enrolling in this health benefit plan, you have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

Binding Arbitration

Except for: (1) claims filed in Small Claims Court; (2) Claims subject to the Colorado Health Care Availability Act, Section 13-64-403, C.R.S.; (3) claims subject to the provisions of Colorado Revised Statutes, Section 10-3-1116(1); and (4) Claims subject to Medicare Appeals procedures, Chapter 13 of the Medicare Managed Care Manual; your enrollment in this health benefit plan requires that all claims by You or anyone acting on your behalf, against Us or any of our directors, officers, employees or shareholders, which arise from any alleged failure or violation of, including but not limited to any duty relating to or incident to the this Agreement, must be submitted to binding arbitration before a single neutral arbiter. By enrolling in this health benefit plan, You have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury. You must use Health Plan procedures to request arbitration. You can get a copy of these procedures from Us. The arbitration hearing will be held in accord with the Colorado Uniform Arbitration Act and the Federal Arbitration Act.

Conformity with State Statutes

Any provision of this Policy that, on its Effective Date, is in conflict with the statutes of the State of Colorado is hereby amended to conform to the minimum requirements of such statutes. Any and all provisions of this agreement remain in full force and effect.

Fraudulent Insurance Acts Notice

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company.

Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Insurance fraud results in cost increases for health care coverage. You can help decrease these costs by:

- Being wary of offers to waive Deductible and/or Coinsurance. This practice is usually illegal.
- Being wary of mobile health testing labs. Ask what the insurance company will be charged for the tests.
- Always reviewing Your Explanation of Benefits.
- Being very cautious about giving Your health insurance coverage information over the phone.

If fraud is suspected, contact Us at the *Customer Service* number listed in Section 3 of this Policy and on Your ID card.

We reserve the right to recoup any benefit payments paid on Your behalf, and/or to rescind the coverage under this Policy retroactively as if it never existed if You have committed fraud or intentional misrepresentation of material fact in applying for coverage in or receiving or filing for Benefits.

Time Limit on Certain Defenses

After two years from the effective date of this Policy, in the absence of fraud, no misstatements made by the Subscriber in the enrollment application may be used by Us to cancel this Policy or to deny a claim for Benefits for Covered Health Services received after the expiration of such two-year period. This provision does not apply to a misstatement about age or occupation or other insurance.

After this Policy has been in force for a period of two (2) years, We may not contest any statements contained in the Application.

Notices

All notices are considered sent to and received by You when deposited in the United States mail with postage prepaid and addressed to the address on file with Us.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw, add Benefits, or terminate this Policy, without Your approval, as permitted by law. We must notify You of material changes to this Policy at least 60 days in advance of the change.

On its effective date this *Policy* replaces and overrules any *Policy* that We may have previously issued to You. Any *Policy* We issue to You in the future will in turn overrule this *Policy*. This Policy will take effect on the date specified in this Policy. Coverage under this Policy will begin at 12:01 a.m. and end at 12:00 midnight Mountain Standard Time. This Policy will remain in effect as long as premiums are paid when they are due, subject to termination of this Policy.

We are delivering this Policy in the State of Colorado. To the extent that state law applies, the laws of the State of Colorado are the laws that govern this Policy.

Member Rights and Responsibilities

You Have the Right to:

- Receive medical treatment that is available when You need it and is handled in a way that respects Your privacy and dignity.

- Get understandable information You need about Your health benefit plan, including information about services that are covered and not covered, and any costs that You will be responsible for paying.
- Obtain information about the qualifications of clinical staff that support Our wellness and similar programs.
- Have access to a current list of Network Physicians, Hospitals and places You can receive care, and information about a particular Physician's education, training, and practice.
- Select a primary care Physician for Yourself and each member of Your family who is enrolled, and to change Your primary care Physician for any reason. Although it is highly recommended that you select a primary care Physician, it is not required under this plan in order to receive Benefits.
- Have Your medical information kept confidential by Us and Your Physician. We honor the confidentiality of Covered Person information and adhere to all federal and state regulations regarding confidentiality and the protection of personal health information.
- Participate with Your health care professional in health care decisions, and have Your health care professional give You information about Your medical condition and Your treatment options, regardless of coverage or cost. You have the right to receive this information in terms and language You understand.
- Learn about any care You receive. You should be made aware of any special programs or services that We have made available to assist You, as well as how to enroll, or change programs or services. You should be asked for Your consent for all care, unless there is an Emergency and Your life and health are in serious danger.
- Refuse medical care and disenroll from programs/services offered by Us. If You refuse medical care, Your health care professional should tell You what might happen. We urge You to discuss Your concerns about care with Your primary care Physician or other participating health care professional. Your Physician or health care professional will give You advice, but You will have the final decision.
- Be heard. Our complaint-handling process is designed to: hear and act on Your complaint or concern about Us and/or the quality of care You receive from health care professionals and the various places You receive care in our network; provide a courteous, prompt response; and guide You through Our appeal process if You do not agree with Our decision.
- Make recommendations regarding Our policies that affect Your rights and responsibilities.

You Have the Responsibility to:

- Pay your monthly premium including any outstanding premium due as a result of a retroactive changes to your policy on or before the due date.
- Review and understand the information You receive about Your health benefit plan. Please call *Customer Service* when You have questions or concerns.
- Understand how to obtain services and supplies that are covered under Your plan.
- Show Your ID card before You receive care.
- Schedule a new patient appointment with any Network Provider; build a comfortable relationship with Your Physician; ask questions about things You don't understand; and follow Your Physician's advice. You should understand that Your condition may not improve and may even get worse if You don't follow Your Physician's advice.
- Understand Your health condition and work with Your Physician to develop treatment goals that You both agree upon.
- Provide honest, complete information to the health care professionals caring for You.
- Know what medicine You take, and why and how to take it.
- Pay all Copayments, Annual Deductibles, and Coinsurance for which You are responsible, at the time service is rendered or when they are due.
- Keep scheduled appointments and notify the health care professional's office ahead of time if You are going to be late or miss an appointment.
- Pay all charges for missed appointments and for services that are not covered by Your plan.
- Voice Your opinions, concerns, or complaints to Our *Customer Service* and/or Your health care professional.
- Notify Us and treating health care professional as soon as possible about any changes in family size, address, phone number or status with Your health benefit plan.

Section 12 - Termination/Nonrenewal/Continuation

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained below, as permitted by law.

We will provide You with a thirty (30) day advanced written notice prior to the termination of Your coverage, except if such termination is the result of fraud or intentional misrepresentation of material fact.

- You are actively enrolled under more than one of Our individual or child-only plans. Coverage under the first plan will end as of the effective date of any subsequent Bright Health non-group plan.
- We decide not to renew all of Our individual or child-only plans in the State of Colorado. In this case, We will provide notice of the decision not to renew the plans to all affected individuals and to the State Insurance Commissioner. We will provide notice at least 180 days before Our non-renewal of the plans.
- We decide to discontinue a particular Plan. In this case we will provide ninety (90) days advance written notice to the Subscriber prior to termination of coverage.
- When the State Insurance Commissioner finds that the continuation of Your plan would not be in Your best interest or Your plan is obsolete or Your plan would impair Our ability to meet Our contractual obligations. In this case, We will provide notice of discontinuance at least 90 days prior to the date of discontinuance. We will provide You with the opportunity to purchase any other non-group plan offered by Us.
- We stop operations. We must pay for services for the rest of the time that premiums have already been paid.
- When enrollment was erroneous or inappropriate. If enrollment occurred in error or inappropriately, We reserve the right to rescind the policy.
- We receive a written notice from You instructing Us to cancel Your or Your Dependent's coverage. If any premium has been paid for the time period following the requested date of termination and no claims have been submitted to Us for dates of service after the requested date of termination, we will refund or credit that premium within 30 days of the request for termination. In the case of retractive termination, we will not refund or credit any premium when claims have been submitted to Us for dates of service after the requested date of termination.
- For Individual Policies (not Child-Only): An Enrolled Dependent Child reaches age 26. Coverage for the Dependent Child will end on the last day of the month in which the Dependent Child turns 26.
- The Spousal relationship, as referred to in Our definition of Spouse, is legally dissolved. Coverage for the Dependent Spouse will end on the last day of the month in which the Spousal relationship is legally dissolved. Once We receive notice of the dissolution, We will adjust Your coverage and premium.
- For Individual Child-Only Policies: A Covered Person reaches age 21. Coverage for the Covered Person reaching age 21 will end on the last day of the month in which the Covered Person turns 21.
- The Subscriber's death. Upon the death of the Subscriber, Dependent coverage may be continued under a new policy with a new ID number. Please contact *Customer Service* at the number included on Your ID card for additional information.
- Coverage will end if premiums are not paid when they are due. A Grace Period of 3 months for individuals receiving federal insurance subsidies will be allowed for the payment of all outstanding premiums. If the full balance of outstanding premium is not paid within Your grace period, coverage will end on the last day of the first calendar month of the grace period. For non-subsidized Members, a 31 day grace period will be allowed for the payment of all outstanding premiums. If the full balance of outstanding premium is not paid within Your grace period, coverage will end on the 31st day of the Grace Period. We will provide You notice of Your nonpayment before cancelling Your Policy. We will not pay for any services received on or after the date Your coverage ends.
- Fraud, including improper use of Your ID card or intentional misrepresentation of material

fact. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact may result in termination or rescission of this Policy. This Policy may also be terminated if You participate in or permit fraud or deception by any Provider, vendor, or any other person associated with this Policy. Termination of Coverage will be effective on the date we mail the written notice of termination to You. Rescissions will be as the coverage effective date, and it will be as if You were never covered under this Policy. We will provide You with thirty (30) days written notice prior to rescinding coverage.

Reinstatement of Coverage

If any premium is not paid within the time granted to You for payment, a subsequent acceptance of premium by Us, without requiring an application for reinstatement, shall reinstate the Policy. This is provided, however, that if We require an application for reinstatement and issue a conditional receipt for the premium paid, the Policy will be reinstated upon approval of application by Us or, lacking such approval, upon the forty-fifth day following the date of the conditional receipt unless We have previously notified You in writing of Our disapproval of Your application. The reinstated Policy shall cover only loss resulting from Accidental Injuries sustained after the date of reinstatement and loss due to Illnesses. In all other respects You and Us shall have the same rights as existed under the Policy immediately before the due date of the defaulted premium, subject to any endorsements attached to the reinstated Policy. Any premiums accepted in connection with a reinstatement will be applied to a period for which You have not previously paid premium, but not to exceed sixty days prior to the date of reinstatement.

Section 13 - Appeals and Complaints

Cultural and Linguistic Handling of Denials and Appeals

We are required to provide Culturally and Linguistically Appropriate Notices, which means that We will provide the following:

- Language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language.
- Assistance with filing claims and appeals (including external review) in any applicable non-English language.
- Upon Your request, a non-English version of any notice will be provided to You.
- We will provide the notice of the appeals process in a culturally and linguistically appropriate manner, in any County within our Service Area that has attained the threshold of 10% or more of the population being literate in the same non-English language as determined by the Department of Health and Human Services (HHS) and documented at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/clas-data.html,

What to Do if You Have a Question

Contact *Customer Service* at the telephone number listed in Section 3 of this Policy and on Your ID card. *Customer Service* representatives are available to take Your call and resolve Your inquiry.

What to Do if You Have a Complaint

Contact *Customer Service* at the telephone number listed in Section 3 of this Policy and on Your ID card. *Customer Service* representatives are available to take Your call.

If You would rather send Your complaint to Us in writing, the *Customer Service* representative can provide You with the appropriate address.

If the *Customer Service* representative cannot resolve the issue to Your satisfaction over the phone, he/she can help You prepare and submit a written complaint. We will notify You of Our decision regarding Your complaint within 30 days of receiving it.

Appeal of an Adverse Determination

If You disagree with an Adverse Determination and wish to appeal, You may request a review of the Adverse Determination. We have an internal review process. Once You have gone through the internal appeals process, if further review is necessary, You may request an independent external review.

Internal Review Process

To begin the internal review process, You must send a written request to Us at the address on Your ID card.

Your request for an appeal must include:

- A description of the Adverse Determination;
- The reason You disagree with the Adverse Determination; and
- Any documentation (including medical records) or other written information to support Your position.
- If the Adverse Determination is based on a contractual exclusion, You must submit evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply.
- If Your appeal is related to a claim, the request for the appeal must include the following information:
  - The patient's name and the identification number from the ID card;
  - The date(s) of the medical service(s); and
  - The provider's name.

Appeal Review Process
Your appeal request must be submitted to Us within 180 days after You receive notice of the Adverse Determination You are appealing.

Appeals will be evaluated by a Physician or dentist, as appropriate, who will consult with clinical peers with the appropriate expertise, if necessary. No Physician, dentist, or peer who was involved in the initial Adverse Determination will be involved in the first-level appeal review, but may be called upon to answer questions regarding the initial Adverse Determination.

The reviewer will consider all comments, documents, records, and other information You submit, without regard to whether the information was submitted or considered in making the initial Adverse Determination.

If the appeal is about the applicability of a contractual exclusion, the review determination will be made based on whether the contractual exclusion applies to the denied benefit.

Notice of Appeal Determination
Within thirty (30) days of receipt, We will provide You with a written notice of our determination along with a detailed explanation of the basis for that determination and, if the Initial Adverse Determination was upheld, of the process for requesting an external review.

Expedited Appeals

Expedited Appeal Review Process
If a delay in treatment could significantly increase the risk to Your health, cause severe pain, or affect Your ability to regain maximum function, Your appeal may require immediate action. In these situations, You, Your Physician, or Your designated representative may request an expedited appeal.

An expedited appeal request does not need to be submitted in writing. An expedited review may be requested by calling us directly at the *Customer Service* number listed in Section 3 of this Policy and on Your ID card.

We will consider all comments, documents, records, and other information provided without regard to whether the information was submitted or considered in making the initial Adverse Determination. If additional information is necessary to complete an expedited review, We will notify the individual who requested the review within 24 hours of Our receipt of the expedited appeal request.

Notice of Expedited Appeal Determination
We will make a decision and notify You, Your Physician, and/or Your designated representative as expeditiously as possible. Our initial notification will be by telephone, fax, or electronic means.

In no case will our initial notification be provided more than 72 hours after Our receipt of the expedited appeal request or the information necessary to make a determination.

We will confirm Our initial notification in a formal letter within three (3) business days of Our initial communication.

If the expedited review is concurrent with the receipt of Health Care Services, those services shall continue without liability to You until We provide You, Your Physician, or Your designated representative with our initial appeal determination.

Independent External Review

Independent External Review Process
After You have gone through the internal appeal, You may request an independent external review. We are responsible for paying the cost of the independent external review; there is no cost to You. To begin the process, You, Your Physician or Your designated representative must submit a written request for an independent external review no later than four (4) months after receiving notice of

the appeal determination from the internal appeal. You may also submit Your request for an independent external review at the same time You request an expedited internal review.

Independent external review requests must be submitted to Us in writing and include a completed external review request form as specified by the Colorado Division of Insurance (the Division). You must also include a signed consent form, authorizing Us to disclose protected health information, including medical records, pertinent to the external review. You may include with Your request new information, if it is significantly different from the information provided or considered during the internal review process.

We will forward a copy of Your request to the Division. The Division will select an independent external review entity to review Your request and notify Us of their selection. We will notify You of the review entity selected by the Division and provide You with information on how to address potential conflicts of interest.

Within five (5) working days of receiving notice of the review entity assignment, You may submit additional information for consideration directly to the review entity. The review entity will forward to us a copy of any information You send them. We will send the review entity documents and information considered in making Our Adverse Determination. The review entity will provide You with an index of all materials that We submit. Upon request, We will provide You with all relevant information we supply to the review entity that is not confidential or privileged under state or federal law concerning the case under review. The review entity will notify You and Us if additional information is required.

We have the option of reversing Our Adverse Determination based on a consideration of any new information You may submit. If we reverse our Adverse Determination, We will notify You, the Division, and the review entity within one working day of the decision to reverse the Adverse Determination. Upon receiving that notification from Us, the review entity will terminate the external review.

Notice of Independent External Review Determination
Within forty-five (45) days of receiving the request for review, the review entity will decide whether to uphold or reverse Our Adverse Determination and send written notice of that decision to You, Your Physician, Us, and the Division. The decision of the review entity is binding.

If the review entity reverses Our Adverse Determination and the review was concurrent or prospective, We will approve coverage within one (1) working day of receiving the review entity's decision. If the review entity reverses Our Adverse Determination and the review was retrospective, We will approve Benefits within five (5) working days and notify You within one (1) working day of that approval. Benefits will be provided based on the terms and conditions of Your plan.

Expedited Independent External Review

Expedited Independent External Review Process
You, or Your designated representative may request an expedited independent external review if You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize Your life, health, or ability to regain maximum function, or create an imminent and substantial limitation to Your ability to live independently. The review request must include a Physician's certification that Your medical condition meets this requirement. The request may be made simultaneously with an internal expedited appeal request.

Your request must be submitted to Us in writing and include a completed external review request form as specified by the Colorado Division of Insurance (the Division) and as available at www.brighthealthplan.com. You must also include a signed consent form, authorizing Us to disclose protected health information, including medical records, pertinent to the external review. You may include with Your request new information, if it is significantly different from the information provided or considered during the internal review process.

We will forward a copy of Your request to the Division within one (1) working day. Within one (1) working day of receiving the request, The Division will select an independent external review entity to review Your request and notify Us of their selection. We will notify You of the review entity selected by the Division and provide You with information on how to address potential conflicts of interest.

Immediately upon receipt of the review entity assignment, We will send the review entity documents and information considered in making Our Adverse Determination.

Notice of Expedited Independent External Review Determination
Within seventy-two (72) hours of receiving the request for an expedited review, the review entity will decide whether to uphold or reverse Our Adverse Determination and send written notice of that decision to You, Your Physician, the Division, and Us. The decision of the review entity is binding. If the preceding initial notice is not provided in writing, the review entity will provide a formal written confirmation within forty-eight (48) hours of the initial notice.

If the designated review entity reverses our determination, We will reverse any Benefit determinations immediately upon notification and provide a written notification of Benefits within one (1) working day. Benefits will be provided based on the terms and conditions of Your plan.

Important Notice – Claims Disputes
Should a dispute concerning a claim arise, call Us at the phone number listed in Section 3 of this Policy and on Your ID card. If the dispute is not resolved, You may contact the Colorado Division of Insurance.

Write the Colorado Division of Insurance at:
Colorado Division of Insurance
1560 Broadway
Suite 850
Denver, CO 80202
(Fax: 303-894-7455)

To file a complaint electronically, please visit the Colorado Division of Insurance Website at *http://www.dora.state.co.us.*

Section 14 - Information on Policy and Rate Changes

Changes to this Policy

We may change Your *Policy* by adding Amendments. Amendments are legal documents that change certain parts of the Policy. If we make a change, we must notify You at least 60 days before we make the change.

Changes In Covered Persons

The amount You pay for the Policy depends on who is covered by the Policy. If You change who is covered under the Policy, the monthly premium will change as of the effective date of the change in enrollment.

Changes to Premium Charge

Your Premium charges may change as permitted by law. Premiums will not change more than once a year unless there is a change to who is enrolled, You choose a different plan during a Special Enrollment Period, or if you move.

Misstatement of Age

If the incorrect age of a Covered Person has been given to us, the amount You owe will be based on the correct age.

Address Changes

If You move to a new address, Your premium amount may change. Notify Us in writing at least 30 days before You move. This will ensure Your premium statement is sent to Your new address. When You notify Us of Your new address, any premium change will be effective on the first of the month following Your move. If You do not notify Us of a change in address and We learn of the change later, We may bill You for the difference in premium from the date the address changed.

Renewal of Policy

If You do not take action to cancel or change Your plan or if we have not been otherwise notified, Your Policy will renew automatically each year on January 1st at the new premium amount. Prior to the renewal, you will be notified of the new premium amount.

Section 15 - Definitions

Adverse Determination means:

- A denial of a Pre-authorization for covered Benefits;
- A denial of a request for Benefits on the ground that the treatment or covered benefit is not Medically Necessary, appropriate, effective or efficient, or is not provided in or at the appropriate health care setting or level of care;
- A retroactive rescission or cancellation of coverage not attributable to failure to pay premiums;
- A denial of excluded Benefits, when evidence is provided that there is a reasonable medical basis that the contractual exclusion doesn't apply; or
- A denial of a request for Benefits on the grounds that the treatment or service is experimental or investigational.

Allowable Amount - for Covered Health Services, incurred while this Policy is in effect, Allowable Amounts are determined by Us as stated below and as detailed in the Schedule of Benefits (Who Pays What) section of this Policy.

For Covered Health Services received from a Network Provider, the Allowable Amount is Our Contracted Rate with that provider.

When receiving care from a Non-Network Provider at a Non-Network facility, payment from the Plan will be limited to the Allowable Amount. The Allowable Amount is the amount negotiated by Us with the Non-Network Provider, or up to 160% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, whichever is less.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Abuse Services on an outpatient or inpatient basis.

Ancillary Provider - a provider whose services may include anesthesiology; pathology; hospital or facility physician services; radiology; physical, speech and occupational therapies rendered in a Facility setting; and ambulance services.

Annual Deductible - the amount You must pay towards any Allowed Amounts for Covered Health Services incurred in a calendar year, before We will begin paying for Benefits.

Hospital expenses are incurred on the date of admission. Medical expenses are incurred on the date that services are rendered. The amount that is applied to the Annual Deductible is calculated on the basis of Allowed Amount. The Annual Deductible does not include any amount that exceeds the Allowed Amount.

Refer to the *Schedule of Benefits (Who Pays What) section of* this *Policy* to determine whether or not Your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Autism Spectrum Disorders - Autism is a developmental Disorder of brain function classified as one of the pervasive mental developmental Disorders. These disorders can vary widely in severity and symptoms; classical autism is characterized by impaired social function, problems with verbal and nonverbal communication and imagination, and unusual or severely limited activities and interests.

Benefits - Your right to payment for Covered Health Services that are available under this Policy. Your right to Benefits is subject to the terms, conditions, limitations, and exclusions of this Policy, which includes the *Schedule of Benefits* along with any attached Amendments.

Biologically Based Mental Illnesses - the following conditions as described in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

Brand-Name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that is identified as a Brand-name product, based on available data resources including, but not limited to, Medispan, that classify drugs as either brand-name or Generic based on a number of factors. You should know that all products identified as "brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as Brand-name by Us.

Chemically Equivalent – when Prescription Drug Products contain the same active ingredient.

Child - means any of the following who are under the age of 26, the Subscriber or Dependent's:

- natural child
- stepchild
- legally adopted child
- foster child
- child placed for adoption
- child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order
- child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's Spouse

A Child will continue to be eligible until the end of the month in which they reach age 26 if he or she continues to meet all other eligibility requirements.

Child Health Supervision Services – those preventive services and immunizations required to be provided to an Enrolled Dependent Child up to age 13 as follows:

- 0-12 months: One newborn home visit during the first Week of life if the newborn is released from the Hospital less than 48 hours following delivery; six (6) Well-child visits; one (1) PKU.
- 13-35 months: Three (3) Well-child visits
- 3-6 years: Four (4) Well-child visits
- 7-12 years: Four (4) Well-child visits
- 0-12 years: Immunizations

Child-Only Policy – a Policy for which coverage is provided for children under age 21, without a parent or legal guardian enrolling.

Chronic Condition – a human health condition or disease that is persistent or otherwise long-lasting in its effects or a disease that comes with time. The term chronic is usually applied when the course of the disease lasts for more than three (3) months. Common chronic diseases include Asthma, diabetes, hypertension, hypercholesterolemia.

Coinsurance - the percentage of any Allowed Amount that You are required to pay for certain Covered Health Services.

Complications of Pregnancy - are conditions (when the Pregnancy is not terminated), whose diagnoses are distinct from the Pregnancy, but are adversely affected by the Pregnancy or caused by the Pregnancy, including, but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also include non-elective cesarean section, termination of ectopic Pregnancy, and spontaneous termination of Pregnancy, which occurs during a period of gestation in which a viable

birth is not possible, Complications of Pregnancy do not include false labor, occasional spotting, morning Sickness, Physician prescribed rest during the period of Pregnancy, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult Pregnancy not constituting a distinct complication of Pregnancy.

Continuity of Care - is the process by which the member and Network Provider, who is exiting the network, wish to continue ongoing health care management and treatment for certain health conditions for a defined period of time.

Contracted Rate - is the amount that We have agreed to pay Our Network providers or Pharmacy Services Vendor.

Congenital Anomaly - a physical developmental defect that is present at the time of birth.

Copayment - the charge stated as a set dollar amount that You are required to pay for certain Covered Health Services.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by Us.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which We determine to be all of the following:

- Unless otherwise specified, are provided for the purpose of diagnosing or treating a Sickness, Injury or associated symptoms.
- Consistent with nationally recognized Scientific Evidence as available, and Prevailing Medical Standards and Clinical Guidelines.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in the *Benefits/Coverages (What is Covered)* and in the *Schedule of Benefits (Who Pays What)* sections of this *Policy*.
- Not otherwise excluded in the *Limitations/Exclusions (What is Not Covered*) *section of this Policy*.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under this Policy. References to "You" and "Your" throughout this *Policy* are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring, and ambulating).
- Health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Days' Supply Limit - This is the number of days of therapy You can receive for each prescription filled and re-filled under this benefit. At a Retail Pharmacy, You can receive up to a 30 consecutive day supply of a medication for each fill or re-fill. At a Mail Order Pharmacy, You can receive up to a 90 consecutive day supply of all medication except Specialty Drugs for which You may receive a 30- consecutive day supply for each prescription filled and re-filled, depending on the medication. These supplies may be reduced by Your prescriber, pharmacist, or state laws impacting Your prescription medication.

Dependent - the Subscriber's Spouse, Domestic Partner or Child who resides within the United States.

Designated Beneficiary – person named as Your Designated Beneficiary in a Designated Beneficiary Agreement.

Designated Beneficiary Agreement - allows two unmarried people to affirm in writing that they want each other to have legal rights, benefits, and protections to make certain decisions about each other's health care and estate administration as well as treatment in medical emergencies, during incapacity, and at death.

Designated Pharmacy – a pharmacy that has entered into agreement with Us or Our Pharmacy Services Vendor to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury, or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury, or their symptoms.
- Is not implantable within the body.

Eligible Individual – a person eligible to enroll in a Policy**.**

Emergency - the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of medicine and health, could reasonably expect, in the absence of immediate medical attention, may result in:

- Placing the health of the Covered Person in serious jeopardy.
- Serious impairment to a bodily function.
- Serious dysfunction of any bodily organ or part.
- Inadequately controlled pain.
- With respect to a pregnant woman who is having contractions, either of the following:
  - Inadequate time to affect a safe transfer of a pregnant woman to another Hospital before delivery.
  - The transfer to another Hospital may place the health of the woman or unborn child in serious jeopardy.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency, including a medical screening examination that is within the capability of the Emergency department of a Hospital (including ancillary services routinely available to the Emergency department to evaluate the Emergency) and, within the capabilities of the staff and facilities available at the Hospital, further medical examination and treatment as required to stabilize the Covered Person to assure, within reasonable medical probability, that no material deterioration of the Covered Person's condition is likely to result from or occur during the transfer of the Covered Person from a facility, if needed.

Enrolled Dependent – An eligible Child or Spouse who is properly enrolled under this Policy.

Exchange, also known as the Marketplace, or Connect for Health Colorado - is a transparent and competitive online insurance marketplace where individuals and small businesses can buy qualified health benefit plans. The Exchange offers a choice of health plans that meet certain benefits and cost standards.

Experimental, Investigational Service or Unproven Service(s) - medical, surgical, diagnostic, psychiatric, Substance Abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time We make a determination regarding coverage in a particular case, are determined to be any of the following:

- has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
- is the subject of a current new drug or new device application on file with the FDA; or

- is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity or efficacy of the Service; or
- is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity or efficacy as among its objectives; or
- is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity or efficacy of Services; or
- the Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
- is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity or efficacy; or
- is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity or efficacy of the Service.

Facility – an inpatient or outpatient hospital or freestanding surgical institution.

Family Annual Deductible – two times the Annual Deductible for an individual subscriber.

Formulary/Formulary Drugs – A list of medications provided from Our Pharmacy Services Vendor to help Us determine Your cost for certain prescriptions. The Formulary is reviewed by an independent committee working with Our vendor and updated at least four (4) times per year. Products on the Formulary are generally offered to You at the lowest cost under the benefit. Products not on the Formulary generally cost You more under this benefit.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-Name drug; or (2) that is identified as a Generic product based on available data resources including, but not limited to, Medispan, that classify drugs as either brand-name or Generic based on a number of factors. You should know that all products classified as "Generic" by the manufacturer, pharmacy or Your Physician may not be classified as a Generic by Us.

Habilitative Services - health care services that help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. These services address the competencies and abilities needed for optimal functioning in interaction with their environments. Examples include therapy for a child who isn't walking or talking at the expected age. Adults, particularly those with intellectual disabilities or disorders such as cerebral palsy, can also benefit from Habilitative Services. Habilitative services include physical therapy, occupational therapy, speech-language pathology, audiology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Hearing aid - amplification technology that optimizes audibility and listening skills in the environments commonly experienced by the patient, including a wearable instrument or device designed to aid or compensate for impaired human hearing. "Hearing aid" shall include any parts or ear molds.

Hearing Screening - exams and tests to determine the need for hearing correction.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - a legally constituted institution, having organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under supervision of a staff of one or more licensed Physicians and which provides 24-hour nursing services by registered nurses on -duty or -call. It does not mean convalescent, nursing, rest, or extended care facilities or facilities operated exclusively for treatment of the aged,

drug addict or alcoholic, even though such facilities are operated as a separate institution by a Hospital.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under this Policy.

Inherited Enzymatic Disorder – a disorder caused by single or small number of gene defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions including, but not limited to the following diagnosed conditions:

- Phenylketonuria in Covered Persons who are less than 21 years of age.
- Maternal phenylketonuria in female Covered Persons of childbearing age who are less than 35 years of age.
- Maple syrup urine disease
- Tyrosinemia;
- Homocystinuria;
- Histidinemia;
- Urea cycle disorders;
- Hyperlysinemia;
- Glutaric acidemias;
- Methylmalonic ademia;
- Proprionic academia;
- Immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins;
- Severe food protein induced enterocolitis syndrome;
- Eosinophilic disorders as evidenced by the results of a biopsy; and
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a facility that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intermediate Care - Mental Health/Substance Abuse treatment that encompasses the following:

- Care at a residential treatment center which provides a program of effective Mental Health/Substance Abuse treatment and meets all of the following requirements:
  - It is established and operated in accordance with any applicable state law.
  - It provides a program of treatment approved by a Physician and the Mental Health/Substance Abuse Designee.
  - It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
  - It provides at least the following basic services:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.[8]
    - Care at a partial Hospital/day treatment program, which is a freestanding or Hospital-based program that provides services for at least 20 hours per Week and continuous treatment for at least 3 hours but not more than 12 hours in any 24-hr period.
    - Care through an intensive outpatient program, which is a freestanding or Hospital-based program that provides services for at least nine hours per Week. This encompasses half-day (i.e. less than four hours per day) partial Hospital programs.[5]

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each Week; or

- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Mail Order Pharmacy - A pharmacy contracted or owned by Our Pharmacy Services Vendor for receiving, managing, and dispensing prescriptions via use of the United States Postal Service, or other private carriers able to ship medications to You.

Maximum Allowable Cost (MAC)/Maximum Reimbursement Amount List - a list of Generic Prescription Drug Products along with established prices that Our Pharmacy Services Vendor has created. The list is maintained by Our Pharmacy Services Vendor and We use a list to price most of the Generic medications available under this benefit. This list is subject to periodic review and modification.

Medical Foods - prescription metabolic formulas and their modular counterparts that are:
- Obtained through a pharmacy.
- Specifically designated and manufactured for the treatment of Inherited Enzymatic Disorders caused by gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist.
- Specifically processed or formulated to be deficient in one or more nutrients and are able to be consumed or administered internally either via tube or oral route under the direction of a Physician.

The term “Medical Foods” does not include foods for cystic fibrosis patients or lactose, gluten, or soy intolerant patients.

Medically Necessary/Medical Necessity – a service, procedure or intervention which is recommended by a Physician to treat a medical condition which is known to be effective in improving health outcomes and is the most appropriate supply or level of service considering the Benefits and harms to the patient.

We use these terms to help Us determine whether a particular service or supply will be covered. When possible, We develop written criteria (called medical criteria) that We use to determine Medical Necessity. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that We make available to the medical community and our members. We do this so that You and Your providers will know in advance, when possible, what We will pay for. If a service or supply is not Medically Necessary according to one of our published medical criteria policies, We will not pay for it. If a service or supply is not addressed by one of our published medical criteria policies, We will consider it to be Medically Necessary only if we determine that it is:
- Appropriate and necessary for the symptoms, diagnosis, or treatment of Your medical condition;
- Provided for the diagnosis or direct care and treatment of Your medical condition;
- In accordance with standards of good medical practice accepted by the organized medical community;
- Not primarily for the convenience and/or comfort of You, Your family, Your physician, or another provider of services; Not “investigational”; andPerformed in the least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A "setting" may be Your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only Your medical condition is considered in deciding which setting is Medically Necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As Your medical condition changes, the setting You need may also change. Ask Your physician if any of Your services can be performed on an outpatient basis or in a less costly setting.

It is important for You to remember that when We make medical necessity determinations, We are making them solely for the purpose of determining whether to pay for a medical service or supply.

All decisions concerning Your treatment must be made solely by Your attending physician and other medical providers.

Medicare - Parts A, B, C, and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Disorder – includes but is not limited to post-traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, and agoraphobia with panic disorder, anorexia nervosa, bulimia nervosa, and general anxiety disorder. For the purpose of this coverage, Mental Disorder may also include other diagnoses made by an appropriately licensed health professional and/or approved by Us.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Disorders and Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic *and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under this Policy.

Network Benefits - reimbursement levels for services and supplies that are received from Network/Participating Providers. Detailed information regarding Your Network Benefits is contained on the Network Benefit provision and the Schedule of Benefits (Who Pays What) *section of this Policy*.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with Us or Our Pharmacy Services Vendor on Our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by Us as a Network Pharmacy.

New Prescription Drug Product – a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA and ending on the earlier of the following dates:

- The date it is assigned to a tier by Our Pharmacy Therapeutics Committee.
- December 31st of the following calendar year.

Network Provider or Participating Provider - means a provider that has a participation agreement in effect (either directly or indirectly) with Us. Providers who agree to discount their fees for Our Subscribers without signing a participation agreement are NOT Network/Participating Providers.

Non-Network Benefits - reimbursement levels for services and supplies that are received from Non-Network/Non-Participating Providers. In most cases these services would not be covered by Us.

Non-Network Provider or Non-Participating Provider - means a provider that has not signed a participation agreement with Us to participate in Our plan. Providers who agree to discount their fees for Our Subscribers without signing a participation agreement are Non-Network/Non-Participating Providers.

Non-Network Pharmacy - A pharmacy that does not participate in the contract with Our Pharmacy Services Vendor. These pharmacies may fill Your prescriptions, but Your plan does not provide any coverage for prescriptions filled at these pharmacies. ***There is NO COVERAGE for medications received from a Non-Network Pharmacy.***

Off-Label Use – A Prescription Drug Product approved by the FDA, which is prescribed for a use that is different from the use for which it is approved by the FDA.

To qualify for Off-Label use, the drug must be recognized for the specific treatment for which the drug is being prescribed by one of the following: (1) *U.S. Pharmacopoeia Dispensing Information;* (2) *American Medical Association's Drug Evaluations;* or (3) *American Hospital Formulary Service Drug Information,* or (4) it is recommended by two articles from major peer reviewed medical journals. A Prescription Drug Product includes a drug approved by the FDA prescribed to treat cancer during certain clinical trials as described in this Policy.

Out-of-Pocket Maximum - the maximum amount of Deductible, Coinsurance, or Copayments You pay every calendar year.

Refer to the *Schedule of Benefits (Who Pays What) section of this Policy* to determine whether or not Your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Pharmaceutical Product(s) - FDA-approved prescription Pharmaceutical Products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under this Policy.

Pharmacy Services Vendor - A contracted organization working on behalf of Us to support the delivery of Our prescription medication Benefits to You. Pharmacy Services Vendors manage contracts, connections, and the technology supporting prescription Benefits.

Physician - any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Note: *Other providers may include audiologist, certified respiratory care practitioner, chiropractor, clinical social worker, dentist, dietitian, dispensing optician, marriage, family and child counselor, mental health clinical nurse Specialist, nurse midwife, nurse practitioner, obstetrician/gynecologist, occupational therapist, optometrist, pharmacist, physical therapist, podiatrist, psychologist, psychiatric-mental health nurse, respiratory care practitioner, speech-language pathologist, or other provider who acts within the scope of his or her license. The fact that We describe a provider does not mean that Benefits for services from that provider are available to You under this Policy.*

Plan Year – is a traditional calendar year. If Your initial effective date is other than January 1, Your initial Plan Year will be less than twelve-months, beginning on Your actual effective date and running through December 31 of that same year.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:
- This Policy, which includes the Schedule of Benefits.
- The enrollment application.
- Amendments.

Pre-authorization – the process of collecting information prior to selected procedures, diagnostic studies, medical equipment or medications, and checking to make sure that the requested care meets selected clinical protocols and standard cost-effectiveness analysis. Pre-authorization does require judgment or interpretation for Benefits coverage. That coverage determination is based on plan documents, information from the provider, information from nationally recognized guidelines, and occasionally input from a nationally recognized expert in the field relevant to the requested care.

Pregnancy - includes all of the following:
- Prenatal care
- Postnatal care
- Childbirth
- Any Complications of Pregnancy

Premium - the monthly fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of this Policy.

Prescription Drug Product - a medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive. Also refers to the claim for such services when submitted to Our Pharmacy Services Vendor.

Prevailing Medical Standards and Clinical Guidelines - nationally recognized professional standards of prevention, diagnosis, or care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

Preventive Drugs - select medications prescribed to prevent the occurrence of specified diseases or conditions for individuals with risk factors or to prevent the recurrence of a disease or condition for those who have recovered. These do not include drugs being used to treat an existing Injury, Sickness or condition.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice, or general medicine.

Pre-Authorization Medications - some medications may require Pre-Authorization to be covered. In these cases, Your Physician and/or pharmacist will be notified. Pre-Authorization is used to verify certain requirements have been met before covering a specific type of service or Prescription Drug Product.

Qualifying Life Event – a life event that involves a change in family status, such as marriage or birth of a child, or loss of other health coverage.

Quantity Limit or Supply Limits - this is a specific Quantity Limit You can receive that may be different than the Days' Supply Limit. In general, these limits are based on maximum dosing and safety for the medication You are receiving. These limits may also be set for purposes of managing Our costs in providing this benefit to You.

Referral - an approval You must receive from Your PCP in order for the services of a Participating Provider, other than the PCP. Services to a participating Obstetrician/Gynecologist and services for Pediatric Dental Care and Pediatric Vision Care do not require a referral.

Rehabilitative Services - health care services that help a person keep, restore, or improve skills and functioning for daily living and skills related to communication that have been lost or impaired because a person was sick, injured, or disabled. These services include physical therapy, occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Responsible Adult – in the case of a Child-only Plan, the person who enters into this Policy on behalf of the child(ren).

Retail Clinic – a walk-in medical clinic located in retail stores, supermarkets and pharmacies that provides treatment for uncomplicated minor illnesses and preventative health care services.

Retail Pharmacy – a pharmacy in Your community that is allowed to dispense medications in accordance with its State laws. Not all Retail Pharmacies are part of Our Pharmacy Network.

Scientific Evidence - means the results of controlled clinical trials, epidemiologic studies, or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a

private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - a Service Area is an area (based on full or partial counties) where Covered Health Services are generally available and readily accessible to Covered Persons.

Sickness - Physical disease, physical illness and Pregnancy.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice, or general medicine.

Specialty Prescription Drug Product and the Specialty Pharmacy Network Supplier – medications listed as Specialty Prescription Drug Products by Our Pharmacy Services Vendor, usually based on their need for specialty dosing, handling, shipping, storage, distribution, or other reasons. These products must be dispensed through Our Specialty Pharmacy Network Supplier in order to maximize Your benefit. Failure to use a Specialty Pharmacy Network Supplier for these medications may cause them to be treated as Out of Network claims.

Spouse – Your legal Spouse, common-law Spouse, partner in a civil union, Domestic Partner or Designated Beneficiary as defined in Article 22 of Title 15, C.R.S.

Subscriber - an Eligible Person who is properly enrolled under this Policy. The Subscriber is the person (who is not a Dependent) on whose behalf this Policy is issued.

Substance Abuse Services - covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Telemedicine - the delivery of medical services and diagnosis, consultation, or treatment using interactive audio, interactive video, or interactive data communication. Consultation provided by a provider using telephone or facsimile machine is not telemedicine. Telemedicine visits are considered office visits and the applicable office visit copayment, coinsurance and/or deductible applies.

Therapeutically Equivalent - when Prescription Drug Products can be expected to produce essentially the same therapeutic outcome and toxicity.

Transition of Care –allows you to continue to receive services for specified medical and behavioral conditions for a defined period of time with doctors, hospitals, and Providers who are Non-Network until the safe transfer of care to a Preferred Provider can be arranged.

Urgent Care Center - a walk-in facility focused on the delivery of ambulatory care and primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an ER visit. Urgent care centers are distinguished from similar ambulatory healthcare centers such as Emergency departments and convenient care clinics by their scope of conditions treated and available facilities on-site.

Usual and Customary Charge - is the median rate paid for similar healthcare services within the surrounding geographic area in which the charges were incurred. The surrounding geographic area may be determined by the type of service and the access to that service in the geographic region.