bright HEALTH

2020
Certificate of Coverage

BrightHealthPlan.com

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

Plan Effective Date: January 1, 2020

This Policy is being issued by Bright Health Insurance Company of Florida, a subsidiary of Bright Health, Inc., 219 N. 2nd Street, Suite 401, Minneapolis, MN 55401.

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 a network of Participating Providers 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;
- You are treated by a Non-Network Provider when you are receiving care at a Network Facility; or when
- We Pre-Authorize care to a Not-Network Provider because 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 Customer Service at (855) 521-9339.

RIGHT TO CANCEL OR RETURN THIS POLICY
If for any reason you are not satisfied with the plan, you may return it to us with your identification card within 10 days following your effective date. We will refund any fees you have paid and obtain refunds for any benefits that we have paid to you or your provider.

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	$2,700	Individual	$8,150
Family	$5,400	Family	$16,300

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Allergy Services

Allergy testing and 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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Physician Services		$50 per visit	Not covered
Allergy Testing		20% after deductible	Not covered
Allergy Serum		20% after deductible	Not covered

Ambulatory Services - Outpatient Surgery

Outpatient Ambulatory 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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Outpatient Ambulatory Surgery	Services require pre-authorization.	20% after deductible	Not covered
Surgeon Fees	Services require pre-authorization.	20% after deductible	Not covered

Autism Spectrum Disorder Services

Services for the treatment of Autism Spectrum 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 Customer Service at (855) 521-9339 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.	20% after deductible	Not covered
Autism - Applied Behavioral Analysis	Services require pre-authorization.	20% after deductible	Not covered

Chemotherapy and Radiation Treatment

Chemotherapy and Radiation treatment 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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Chemotherapy or Radiation Treatment	Services require pre-authorization.	20% 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.	$0 first 2 visits, then $25 per visit		Not covered
Specialty Care Services	Services require pre-authorization.	$50 per visit		Not covered
Hospital Services	Services require pre-authorization.	20% after deductible		Not covered
Laboratory & Radiology Services	Services require pre-authorization.	20% 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)		$10 per prescription	$25 per prescription	Not covered
Preferred Brand (Tier 3)		$50 per prescription	$125 per prescription	Not covered
Non-Preferred Brand (Tier 4)		20% after deductible	20% after deductible	Not covered
Specialty Medications (Tier 5)		20% after deductible	20% after deductible	Not covered

Diabetic Shoes

Custom shoes for diabetics 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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Custom Shoes for Diabetics	Services require pre-authorization.	20% after deductible	Not covered

Dialysis Services

Dialysis treatment 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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Dialysis Treatment	Services require pre-authorization.	20% after deductible	Not covered

Durable Medical Equipment
Durable Medical Equipment and 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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Durable Medical Equipment and Devices	Services require pre-authorization.	20% after deductible	Not covered

Emergency Health Services and Urgent Care Services
Emergency 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)		20% after deductible	20% after deductible
Emergency Room Services (Ancillary charges)		20% after deductible	20% after deductible
Emergency Ambulance Transport (Ground/Air)		20% after deductible	20% after deductible
Urgent Care Center Services (Facility charges)		$75 per visit	Not covered
Urgent Care Center Services (Ancillary charges)		20% after deductible	Not covered

Genetic Testing and Counseling
Genetic Testing and Counseling 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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Genetic Testing & Counseling	Services require pre-authorization.	20% after deductible	Not covered

Home Health Care
Home Health Care 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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Home Health Services	Limited to 20 days per calendar year. Services require pre-authorization.	20% after deductible	Not covered

Hospice Care Services
Hospice Care must be received from a Participating Bright Health hospice facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Hospice Care	Services require pre-authorization.	20% after deductible	Not covered
Bereavement Support Services		$50 per visit	Not covered

Hospital Services
Services must be received from a Participating Bright Health hospital facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Inpatient Hospital Services	Services require pre-authorization.	20% after deductible	Not covered
Inpatient Rehabilitation Facility Services	Services require pre-authorization.	20% after deductible	Not covered
Surgeon Fees	Services require pre-authorization.	20% after deductible	Not covered
Anesthesia	Services require pre-authorization.	20% after deductible	Not covered
Skilled Nursing Facility	Limited to 60 days per year; Services require pre-authorization.	20% after deductible	Not covered

Infusion Therapy
Infusion Therapy 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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Infusion Therapy	Services require pre-authorization.	20% after deductible	Not covered

Lab, X-Ray and Diagnostic Services

Diagnostic services must be received from a Participating Bright Health 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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Diagnostic Outpatient Laboratory & Radiology & Testing		20% after deductible	Not covered
High-tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	Services require pre-authorization.	20% after deductible	Not covered

Mental Health and Substance Abuse Services

Mental Health and Substance Abuse services must be received from a Participating Bright Health 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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Inpatient Mental Health Care	Services require pre-authorization.	20% 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.	$50 per visit	Not covered
Inpatient Substance Abuse Services	Services require pre-authorization.	20% 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.	$50 per visit	Not covered
Outpatient Electroconvulsive Therapy (ECT)	Services require pre-authorization.	$50 per visit	Not covered

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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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Diagnostic and Preventive Services	Some Pediatric Dental services have limitations. Please refer to Your Certificate of Coverage Policy document for more information regarding covered services, limitations and exclusions of the Pediatric Dental plan.	No charge	No charge
Basic Services		50% after deductible	50% after deductible
Major Services			
Orthodontic Services *Medically necessary orthodontia and prosthodontics*			

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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Pediatric Routine Eye Exam	Limited to 1 refractive eye exam per calendar year to determine the need for vision correction.	No charge	Not covered
Eyeglasses for Children	Limited to 1 pair of glasses per calendar year, including standard frames and standard lenses; or a one-year supply of contact lenses per calendar year.	No charge	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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Physician Administered Medications	Services require pre-authorization.	20% after deductible	Not covered
Prescribed Medical Supplies	Limited to the use of Durable Medical Equipment or in a Home Healthcare setting.	20% after deductible	Not covered
Ostomy Supplies		20% after deductible	Not covered

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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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Primary Care Office Visits	Visits for No Charge include the office visit only. 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.	$0 first 2 visits, then $25 per 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.	$50 per visit	Not covered
Clinic Fees for Office Visits at an Outpatient Clinic (hospital-owned clinic)		20% after deductible	Not covered

Pregnancy - Maternity Services

Maternity services must be received from a Participating Bright Health 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 Customer Service at (855) 521-9339 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.	20% after deductible	Not covered

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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) 521-9339.

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)		$10 per prescription	$25 per prescription	
Preferred Brand (Tier 3)		$50 per prescription	$125 per prescription	
Non-Preferred Brand (Tier 4)		20% after deductible	20% after deductible	
Specialty Medications (Tier 5)		20% after deductible	20% after deductible	

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 Customer Service at (855) 521-9339 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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Prosthetic Limbs	Services require pre-authorization.	20% after deductible	Not covered
Internally Implanted Prosthetic Devices	Services require pre-authorization.	20% after deductible	Not covered
All Other Prosthetic Devices	Services require pre-authorization.	20% 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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Occupational Therapy	Limited to 35 combined visits per year for Occupational Therapy, Physical Therapy, Speech Therapy and Chiropractic Manipulations. No therapy limitation for Occupational and Physical Therapy services for the treatment of autism. Services require pre-authorization.	20% after deductible	Not covered
Physical Therapy		20% after deductible	Not covered
Speech Therapy		20% after deductible	Not covered
Chiropractic Manipulations		20% after deductible	Not covered
Inpatient Habilitation/Rehabilitation	Services require pre-authorization.	20% after deductible	Not covered
Cardiac Rehabilitation	Services require pre-authorization.	20% after deductible	Not covered
Pulmonary Rehabilitation	Services require pre-authorization.	20% 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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Sleep Studies	Services require pre-authorization.	20% 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 Customer Service at (855) 521-9339 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Services for the treatment of Temporomandibular Joint Disorder	Services require pre-authorization.	20% 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 Customer Service at (855) 521-9339 to locate a Participating Provider or Facility.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Organ and Tissue Transplants	Services require pre-authorization.	20% 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

Section 2 - Title Page (Cover Page)
Individual Policy

This document includes important information that describes Your Policy. Your Policy is a legal contract between the Subscriber and Bright Health Insurance Company of Florida, 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).

This Policy contains a Deductible Provision.

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.

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.

RIGHT TO CANCEL OR RETURN THIS POLICY

If for any reason you are not satisfied with the plan, you may return it to us with your identification card within 10 days following your effective date. We will refund any fees you have paid and obtain refunds for any benefits that we have paid to you or your provider.

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.

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

Bob Sheehy
Chief Executive Officer

Section 3 - Contact Us

Please contact Us for more information.

Questions About Your Policy
If You have questions about Your coverage, need assistance resolving a complaint, or need other assistance, please contact Us.

Customer Service:
(855) 521-9339
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) 521-9339.

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) 521-9339.

French Creole
Si oumenm oswa yon moun w ap ede gen kesyon konsènan Bright Health, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan (855) 521-9339.

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) 521-9339.

Portuguese
Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Bright Health, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para (855) 521-9339.

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) 521-9339。

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) 521-9339.

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) 521-9339.

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) 521-9339.

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 (521-9339.

Italian
Se tu o qualcuno che stai aiutando avete domande su Bright Health, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare (855) 521-9339.

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) 521-9339 an.

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) 521-9339로 전화하십시오.

Polish
Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Bright Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumacz em, zadzwoń pod numer (855) 521-9339.

Gujarati
જો તમે અથવા તમે કોઇને મદદ કરી રહ્યા ાો તેમ ાંથી કોઇને Bright Health વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિ નો અવિક ર છે. તે ખર્ય વિન તમ રી ભ ષ મ ાં પ્ર મ કરી શક ર્ છે. ૬ ભ વષર્ો િ ત કરિ મ ટે,આ (855) 521-9339 પર કોલ કરો.

Thai
หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคาถามเกี่ยวกับ Bright Health
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร (855) 521-9339

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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.

OPEN ENROLLMENT PERIOD
The open enrollment period is November 1st through December 15th. During this time, You can make changes to Your coverage.

SPECIAL ENROLLMENT PERIOD
Individuals who experience certain Qualifying Life Events can enroll in, or change enrollment within sixty (60) days of the Qualifying Life Event. For certain triggering events, such as loss of minimum essential coverage, or becoming newly eligible or ineligible for federal subsidy programs, an

individual has sixty (60) days before and after the event to select a plan. The effective date of coverage depends on the qualifying events.

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 non-enrollment 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 Medicaid;
- 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 Florida Office of Insurance Regulation 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 dependent newborn child must be enrolled within 31 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 and foster children (including children newly placed for adoption) are automatically covered for the first 30 days following the date of the adoption or placement for adoption. If You wish to continue enrollment of the child beyond the 31st day, the 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 after the initial 31 days

of coverage. 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*.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when You elect to utilize the services of a Non-Participating Provider for a covered non-emergency service, benefit payments to the Provider are not based upon the amount the Provider charges. The basis of the payment will be determined according to Our out-of-network reimbursement benefit. Non-Participating Providers may bill You for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT. Participating Providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance, copayment, and deductible amounts. You may obtain further information about the Providers who have contracted with Us by visiting Our website or contacting Us or Your agent directly.

THIS IS A NETWORK-ONLY PLAN

This plan uses a Provider Network 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;
- You are treated by a Non-Network Provider when you are receiving care at a Network Facility; or when
- Medically Necessary services that You need are not available from a Network Provider. You must receive pre-authorization from Us prior to receiving care if you need non-emergency services from a Non-Network Provider because the services are not available from a Participating 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.

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;
- You are treated by a Non-Network Provider while You are receiving care at a Network facility; or when
- We authorize Medically Necessary care to a Non-Network Provider because the care is not available from a Network Provider.

Non-Network Providers are not contracted with Us. If You access services from a Non-Network Provider for non-Emergency Health Services and one of the situations listed above does not apply, 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.

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 Out-of-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) 521-9339.

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) 521-9339.

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.

PRE-AUTHORIZED CARE FROM NON-NETWORK PROVIDERS

In a case where We do not have a Network Provider or specialist within Our network to provide services for a covered benefit, We will issue Pre-authorization to see a Non-Network Provider. You will not be denied necessary medical care or charged additional expenses because use of a Non-Network Provider is required. You will be responsible for Your In-Network Deductible, Coinsurance or Copayment amounts.

RECEIVING NON-EMERGENT CARE FROM NON-NETWORK PROVIDERS

There are specific situations when This Plan will cover non-emergent services from Non-Network Providers.

Non-emergent services from Non-Network Providers are covered by the Plan when:

- You are treated by a Non-Network Provider while you are receiving care at a Network facility; and when
- We authorize Medically Necessary care to a Non-Network Provider because the care is not available from a Network Provider.

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.com, or call Us at (855) 521-9339.

When receiving emergency care from a Non-Network Provider in a Non-Network facility, We may negotiate the amount that We will pay to the Non-Network Provider and/or facility.

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 are not covered by Your policy.

PAYMENT FOR CHARGES TO NON-NETWORK PROVIDERS

If You receive Pre-Authorization from Us to receive non-emergency 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.

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.

Non-emergency health services received from Non-Network Providers or received outside of Your Service Area will not be covered unless you have Pre-authorization from Us.

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 an Out-of-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
- Behavioral Health/Substance Abuse (Mental/Nervous/Chemical/Alcohol Dependency)
  - Inpatient Facility
  - Inpatient Rehabilitation
  - Partial Hospitalization
  - Intensive Outpatient Treatment
  - Outpatient Detoxification
- Chemotherapy
- Clinical Trials
- Colonoscopy
- Custom Shoes for Diabetics
- Dialysis, Hemodialysis and Peritoneal Dialysis
- Durable Medical Equipment
- Genetic testing and counseling
- 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
- 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
- Therapeutic injections
- Transplants and transplant related services (including pre and post transplant testing)
- 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.

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.

We will make the final decision on claims for benefits under the policy. When making a benefit determination, we will have discretionary authority to interpret the terms and provisions of the policy. This discretionary authority should not be construed to limit the legal action that may be taken by an insured or beneficiary in accordance with the Legal Actions provision of the policy and any applicable state or federal law.

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.

Services provided by a Non-Network Provider at an In-Network facility, will be reimbursed according to Network reimbursement policies. If You receive care at an In-Network facility, You may be balance-billed for services from Non-Network Providers that provide services during your care such as radiologists, anesthesiologists or pathologists, to name a few.

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* S*ection 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 services are requested within 60 days from the onset of injury and are 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.
- 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.

All Autism Spectrum Disorder treatment must Pre-Authorized by the Plan.

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.

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.

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.

With some Durable Medical Equipment items, We will authorize a rental instead of a purchase. The decision is based on the length of need, the cost of the item and the frequency of servicing. When Durable Medical Equipment is rented, benefits cannot exceed Our Allowable Amount to purchase the equipment. 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 DME. Equipment is expected to last at least five (5) years.

- Coverage is not available to replace lost items.

Replacement of DME solely for warranty expiration, or new and improved equipment becoming available is not covered. Duplicate or extra DME for the purpose of the member's comfort, convenience, or travel is not covered. DME 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 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.

Emergency Health Services
Covered Health Services under this section include services required to transport, stabilize or to initiate treatment in an Emergency situation.

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.

If You are admitted to a Non-Network facility through the emergency room, You, your Physician or Hospital must notify Us within 24 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.

Enteral Nutrition
Prescription and non-prescription enteral formulas for home use are covered when prescribed by a Physician and Medically Necessary to treat inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period.

Coverage to treat inherited diseases of amino acid and organic acids shall include coverage for food products modified to be low protein, up to a Covered Person's 25th birthday.

Family Planning Services
Family Planning Services covered under the Plan include:
- Medical history;
- Physical examinations;
- Related laboratory tests;
- Medical supervision in accordance with generally accepted medical practice;
- Information and counseling on contraception;
- Implanted/injected contraceptives; and
- After appropriate counseling, Covered Health Services connected with surgical therapies (vasectomy or tubal ligation).

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.

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 for home health care are limited to 20 days per calendar year.

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.

Note: If Services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these Services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Health Services; it only expands the setting where Covered Health Services can be performed for coverage purposes.

Infertility Services
Services related to infertility are limited to diagnostic services rendered for infertility evaluation.

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 Services/Skilled Nursing
Covered Health Services under this section include services and supplies provided during an Inpatient Stay in an Inpatient Rehabilitation Facility or Skilled Nursing 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*.)
- Medically Necessary Supplies
- Skilled care, skilled nursing, skilled teaching and skilled rehabilitation and habilitation 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 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.

Coverage for skilled nursing services is limited to 60 days per calendar year.

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 and bags.
  - Skin barriers
- Catheter Supplies
- 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.

Nutritional Evaluation, Counseling, and Self-Management Training
Coverage by the Plan includes medical nutrition evaluation and education services provided by appropriately licensed or registered health care professionals and when:
- Nutritional education is required for a disease in which patient self-management is an important component of treatment; and
- There exists a knowledge deficit regarding the disease that requires the intervention of a trained health professional.
- Chronic Disease Self-Management Training is covered when it has a therapeutic role in the care of a diagnosed chronic disease/condition.

Osteoporosis Screening, Diagnosis & Treatment
Screening, diagnosis, and treatment of osteoporosis are covered for high-risk individuals, including, but not limited to:
- estrogen-deficient individuals who are at clinical risk for osteoporosis;
- individuals who have vertebral abnormalities;
- individuals who are receiving long-term glucocorticoid (steroid) therapy;
- individuals who have primary hyperparathyroidism; and
- individuals who have a family history of osteoporosis.

Ostomy Supplies
The Plan covers Medically Necessary Ostomy supplies for care and cleaning of a temporary or permanent ostomy. Covered supplies include, but are not limited to:

- pouches;
- face plates and belts;
- irrigation sleeves, bags and catheters;
- skin barriers, gauze, adhesive, adhesive remover;
- deodorant; and
- pouch covers.

Outpatient Therapies - Rehabilitative and Habilitative Services
Covered Health Services under this section include short-term outpatient Habilitative Services, limited to 35 visits combined between:
- Physical therapy;
- Occupational therapy; and
- Speech therapy
- Chiropractic care

Coverage for chiropractic care includes 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 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.

Pediatric Dental Care
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. The number and frequency of each of these services are limited. Refer to the Limitations/Exclusions section of this Policy for more information regarding Pediatric Dental Care.

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.

Orthodontic treatment is a benefit only when Medically Necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health. Benefits for medically necessary orthodontics will be provided in periodic payments based on continued enrollment.

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 (1) vision examination is covered each calendar year.

Covered Health Services under this section also includes one pair of eyeglasses, including standard frames and standard lenses, or contact lenses, per calendar year. Contact lenses are limited to a one-year supply in a calendar year period. Eyeglasses and contact lenses are limited to the least expensive professionally adequate materials.

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.

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 Our 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.

In order to find out which medications have a Quantity Limit restriction, refer to the Formulary at www.brighthealthplan.com.

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.

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

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."

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

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

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.

You and/or Your health care provider can ask the plan to make an "exception" to cover a medication or to remove the medication restrictions or limits. If We agree that the exception request 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 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.

Drug Tiers

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

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 the Outpatient Prescription Medications Schedule of Benefits.

- 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 Florida 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 only cover the formulary prescription ingredient. 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 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 Participating 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 refills are subject to the plan's annual Deductible, Copayment, or Coinsurance amounts.

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/.

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.

Drug Manufacturer Coupons
If You receive direct support from a drug manufacturer to reduce the cost of a brand-name prescription drug We will apply the amount of the discount for the brand-name drug to Your Deductible and/or Out-of-Pocket Maximum.

When calculating Your contribution to any out-of-pocket maximum, deductible, copayment, coinsurance or other applicable cost sharing requirement, We will include any amount paid by You or on Your behalf for a prescription drug that is either:
- Without a generic equivalent; or
- With a generic equivalent where You have obtained access to the prescription drug through any of the following:
  - Prior authorization
  - A step therapy protocol
  - Our exceptions and appeals process.

For the purposes of this section, "Generic equivalent" means a drug that has an identical amount of the same active chemical ingredients in the same dosage form, that meets applicable standards of strength, quality and purity according to the United States pharmacopeia or other nationally recognized compendium and that, if administered in the same amounts, will provide comparable therapeutic effects. It does not include a drug that is listed by the United States Food and Drug Administration as having unresolved bioequivalence concerns according to the administration's most recent publication of approved drug products with therapeutic equivalence evaluations.

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;
- Aspirin preventive medication: initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not an increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.

- Bacteriuria screening with urine culture for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, if later;
- Blood pressure screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
- 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. This includes a baseline mammogram at age 35-39; a mammogram every 1 to 2 years for women age 40 years and older; or more frequently based on physician recommendation for a woman at risk for breast cancer due to personal or family history.
- 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 every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting);
- Child health supervision services and childhood immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP);
- Chlamydia screening in sexually active women age 24 years or younger, and in older women who are at increased risk for infection;
- Colorectal cancer screening for colorectal cancer starting at age 50 years and continuing until age 75 years.. At home non-invasive stool DNA colorectal screening tests are subject to Medical Necessity and Pre- Authorization requirements.
- 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. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
- Depression screening for 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. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
- Fall prevention exercise interventions to prevent falls 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 asymptomatic pregnant women after 24 weeks of gestation;
- Gonorrhea prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.
- Gonorrhea screening in sexually active women age 24 years or younger, and in older women who are at increased risk for infection.
- 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;
- 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;
- 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.
- HIV Screening for pregnant women including those who present in labor who are untested and whose HIV status is unknown;
- Hypothyroidism screening for congenital hypothyroidism in newborns;
- Intimate partner violence screening for women of reproductive age, and ongoing support for women who screen positive.
- 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. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
- Obesity Screening and Counseling for adults. The USPSTF recommends that clinicians offer or refer adults with a body mass index of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.
- Obesity screening for children and adolescents. The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.
- Osteoporosis screening with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than age 65 years at increased risk for osteoporosis, as determined by a formal clinical risk assessment tool.
- Osteoporosis screening with bone measurement testing to prevent osteoporotic fractures in women age 65 years and older.
- Perinatal depression counseling and interventions for pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.
- 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;
- Preeclampsia screening in pregnant women with blood pressure measurements throughout pregnancy.
- 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;
- 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 young adults, adolescents, children, and parents of young children about minimizing their exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of 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 non-pregnant persons who are at increased risk for infection;
- Syphilis screening for pregnant women. The USPSTF recommends early screening for syphilis infection in all pregnant women.
- Tobacco use counseling and interventions for nonpregnant adults. The USPSTF recommends that clinicians ask all adults about tobacco, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessations to adults who use tobacco.
- Tobacco use counseling and interventions for pregnant women. The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.

- Tobacco use interventions for children and adolescents. The USPSFT recommends that clinicians provide interventions, including brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
- Tuberculosis screening for latent tuberculosis infection in populations at increased risk.
- Unhealthy alcohol use screening for adults. The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.
- 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.*

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*.

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*.

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.

Second Opinions

You may get a second opinion from a Physician about Your condition. Second opinions are an evaluation of a condition and must be received from a Physician who has training and expertise in the illness, disease or condition associated with the request. Second opinions will be subject to the Plan's benefits.

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 when such services are necessary to treat conditions caused by congenital or developmental deformity, disease or injury.

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*.

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.

Bariatric Surgery

Bariatric surgery or weight loss surgery that modifies the gastrointestinal tract with the purpose of decreasing weight is excluded under this plan.

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.

Routine dental care for adults is excluded.

Treatment of congenitally missing, mal-positioned, or supernumerary teeth is excluded, even if provided as part of treatment for a covered Congenital Anomaly.

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
- Cold-circulating devices
- Cold packs
- TENS units
- 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 to treat sleep apnea or snoring
- 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
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.

Infertility & Reproductive Services
Health care services excluded are:
- Services for treatment of involuntary infertility;
- Services to reverse voluntary, surgically induced infertility;

- Artificial insemination, donor semen, donor eggs and Services related to their procurement and storage.
- All Services and supplies 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;
- Medications to treat Infertility
- Genetic testing of embryos pre or post implantation.

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.

Nutritional Counseling
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 for the treatment of Phenylketonuria (PKU)
- 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.

Pediatric Dental Care - Limitations
- Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services." Optional Services also include the use of specialized techniques instead of standard procedures. If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means the We will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.
- Claims shall be processed in accordance with the Our standard processing policies. The processing policies may be revised from time to time; therefore, We shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.
- If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under the dental Benefits. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.
- Exam and cleaning limitations
  - We will pay for oral examinations (except after hours exams and exams for observation) and routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) no more than once every six (6) months. Periodontal maintenance are limited to four (4) times in a 12-month period. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) not to exceed four (4) procedures in a 12-month period.
  - A full mouth debridement is allowed once in a lifetime, when the Enrollee has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three years, and counts toward the cleaning frequency in the year provided.
  - Note that periodontal maintenance, Procedure Codes that include periodontal maintenance, and full mouth debridement are covered as a Basic Benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.
  - Caries risk assessments are allowed once in 36 months.
- X-ray limitations:

- If a panoramic film is taken in conjunction with an intraoral complete series, We consider the panoramic film to be included in the complete series.
- A complete intraoral series and panoramic film are each limited to once every 60 months.
- Bitewing x-rays are limited to once every six (6) months. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

- The fee for pulp vitality tests are included in the fee for any definitive treatment performed on the same date.
- Topical application of fluoride solutions is limited to twice within a 12-month period.
- A distal shoe space maintainer - fixed - unilateral is limited to children 8 and younger and is limited to once per quadrant per lifetime. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe. The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.
- Sealants are limited as follows:
  - once in 36 months to permanent molars if they are without caries (decay) or restorations on the occlusal surface.
  - repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement.
- Preventive resin restorations in a moderate to high risk caries risk patient - permanent tooth are limited to once per tooth in 36 months.
- Specialist Consultations count toward the oral exam frequency.
- We will not cover replacement of an amalgam or resin-based composite restorations (fillings) within 24 months of treatment if the service is provided by the same Provider/Provider office. Prefabricated crowns are limited to once per Enrollee per tooth in any 60-month period. Replacement restorations within 24 months are included in the fee for the original restoration.
- Protective restorations (sedative fillings) are allowed when definitive treatment is not performed on the same date of service. The fee for protective restorations is included in the fee for any definitive treatment performed on the same date.
- Prefabricated stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16. Replacement restorations within 24 months are included in the fee for the original restoration.
- Therapeutic pulpotomy is limited to baby (deciduous) teeth only; an allowance for an emergency palliative treatment is made when performed on permanent teeth.
- Pulpal therapy (resorbable filling) is limited to once in a lifetime and to primary incisor teeth for Enrollees up to age 6 and for primary molars and cuspids up to age 11. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.
- Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation.
- Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
- Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.
- Palliative treatment is covered per visit, not per tooth, and the fee for palliative treatment provided in conjunction with any procedures other than x-rays or select Diagnostic procedures is considered included in the fee for the definitive treatment.
- Periodontal limitations:
  - Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service.
  - Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same dentist/dental office.
  - Periodontal services, including graft procedures are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.

- Bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
- Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
- Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
- When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a basic benefit and are limited to once in a 24-month period.

- Collection and application of autologous blood concentrate product are limited to once every 36 months.
- Crowns and Inlays/Onlays are covered not more often than once in any 60 month period except when We determine the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues. Services will only be allowed on teeth that are developmentally mature.
- Core buildup, including any pins, is covered not more than once in any 60 month period.
- Prefabricated post and core, in addition to crown is covered once per tooth every 60 month period.
- Resin infiltration of incipient smooth surface lesions is covered once in any 36 month period.
- When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.
- Prosthodontic appliances, implants and/or implant supported prosthetics (except for implant/abutment supported removable dentures) that were provided under any Dental Plan program will be replaced only after 60 months have passed, except when We determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under the pediatric dental plan will be made if We determine it is unsatisfactory and cannot be made satisfactory. Services will only be allowed on teeth that are developmentally mature. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Payment for implant removal is limited to one (1) for each implant within a 60-month period.
- Debridement and/or osseous contouring of a peri-implant defect, or defects surrounding a single implant, and includes surface cleaning of the exposed implant surface, including flap entry and closure is allowed once every 60-month period.
- An implant is a covered procedure of the plan only if determined to be a dental necessity. If an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.
- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Covered Service.
- Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement.
- The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was covered under this Pediatric Dental Plan.
- This Plan limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances applies). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
    - Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.

- Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, relining is limited to one (1) per arch in a 36 month period.
- Tissue conditioning is not allowed as a separate Covered Service when performed on the same day as a denture reline or rebase service.

- Occlusal guards are covered by report for Enrollees age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJ). Occlusal guards are limited to one (1) per 12 consecutive month period. We will not cover the repair or replacement of any appliances for Night Guard/Occlusal Guard. Adjustment of an occlusal guard is allowed once in 12-months following six months from initial placement.
- Limitations on Orthodontic Services
  - Services are limited to medically necessary orthodontics when provided by a Provider and when necessary and customary under generally accepted dental practice standards. Orthodontic treatment is a benefit of the Pediatric Dental Plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained.
  - Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.
  - The automatic qualifying conditions are:
    - Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    - A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
    - A crossbite of individual anterior teeth causing destruction of soft tissue,
    - Severe traumatic deviation.
  - The following documentation must be submitted with the request for prior authorization of services by the Provider:
    - ADA 2006 or newer claim form with service code(s) requested;
    - Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
    - Cephalometric radiographic image or panoramic radiographic image;
    - HLD score sheet completed and signed by the Orthodontist; and
    - Treatment plan.
  - The allowances for comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted.
  - Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.
  - Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Enrollees under the age of 19 and shall be prior authorized.
  - Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Enrollee is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
  - All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
  - When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, We will make an allowance for the cost of a standard orthodontic treatment. The Enrollee is responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist's charge for the specialized orthodontic appliance or procedure.
  - Repair and replacement of an orthodontic appliance inserted under this plan that has been damaged, lost, stolen, or misplaced is not a covered service.

Pediatric Dental Care - Exclusions

We will not pay Benefits for:

- services that are not Essential Health Benefits.
- treatment of injuries or illness covered by workers' compensation or employers' liability laws;
- services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- cosmetic surgery or procedures for purely cosmetic reasons.
- maxillofacial prosthetics.
- provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
- services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.
- treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments.
- any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
- prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
- extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- laboratory processed crowns for teeth that are not developmentally mature.
- endodontic endosseous implants.
- indirectly fabricated resin-based Inlays/Onlays.
- charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- treatment by someone other than a Provider or a person who by law may work under a Provider’s direct supervision.
- charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.
- dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- procedures having a questionable prognosis based on a dental consultant’s professional review of the submitted documentation.
- any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits, will be the responsibility of the Enrollee and not a covered Benefit.
- Deductibles and/or any service not covered under the Pediatric Dental Plan.
- services covered under the Pediatric Dental Plan but that exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- the initial placement of any prosthodontic appliance or implant, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under this Pediatric Dental Plan. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

- services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.
- services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided a prior authorization is obtained.
- missed and/or cancelled appointments.
- actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- dental case management motivational interviewing and patient education to improve oral health literacy.
- non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.

Personal Care, Comfort, and Convenience Items
Personal care, comfort and convenience items not covered by the Plan. Such items are:
- Televisions; telephones; and video players.
- Beauty and barber services.
- Guest services.
- Air conditioners; air purifiers; filters; humidifiers; and dehumidifiers.
- Batteries and battery chargers.
- Car seats and strollers.
- Chairs; bath chairs; feeding chairs; toddler chairs; chair lifts; and recliners.
- Electric scooters and other power-operated vehicles.
- Treadmills and other exercise equipment.
- Home modifications such as elevators; handrails; and ramps.
- Jacuzzis; whirlpools; hot tubs and saunas.
- Mattresses; pillows and motorized beds.
- Medical alert systems.
- Music devices and radios.
- Personal computers.
- Safety equipment.
- Speech generating devices.
- Stair lifts and stair glides.
- Vehicle modifications such as van lifts or hand controls.

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 prosthesis, hair transplants, implants or hair weaving.

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 Drug Exclusions
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
- Medications used to treat Erectile Dysfunction.
- Topical medications for the treatment of onychomycosis of the toenails.
- Allergy serum.
- Medications for the treatment of Infertility.

- 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.

Private Duty Nursing
Services for nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting is excluded from coverage under this plan.

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.

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-Network Provider
Generally, services from Non-Network Providers are not covered.

Exceptions to this exclusion are:
- Emergency Health Services;
- You are treated by a Non-Network Provider while you are receiving care at a Network facility; or when
- We authorize Medically Necessary care to a Non-Network Provider because the care is not available from a Network 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 received in consequence of being intoxicated or under the influence of any narcotic, unless administered on the advice of a physician.
- 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 care/Nursing home care
- 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 if We are unable to negotiate an amount with the Non-Network Provider, Our Allowable Amount will be 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.

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.

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

Written notice of claim 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 is acceptable as submission on paper. Failure to furnish such notice of claim 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.

PROOF OF LOSS

Written proof of loss must be furnished to the insurer within 90 days after the termination of the period for which the insurer is liable and, in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor

reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS

Claims payable under this policy for any loss, other than loss for which this policy provides periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

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 90 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

IMPORTANT NOTICE

Please read the copy of the application attached to this policy. Carefully check the application and write to Us within 10 days, if any information shown on it is not correct and complete. This application is a part of the Policy and the Policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

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.

QUALITY MANAGEMENT PROGRAM

We have developed a Quality Management Program to help Us provide You with quality health care and services.

Through the Quality Management Program, We monitor care and services provided to our members and use the results to identify areas of improvement and implement corrective action, as necessary.

Our Quality Management Program focuses on a number of activities including, but not limited to:

- Patient Safety;
- Confidentiality;
- Preventive health;
- Disease and case management;
- Coordination and continuity of care;
- Quality of care; and
- Appeals and grievances.

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.

INSPECTION OF POLICY

If for any reason you are not satisfied with the plan, you may return it to us with your identification card within 10 days following your effective date. We will refund any fees you have paid and obtain refunds for any benefits that we have paid to you or your provider.

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 will make the final decision on claims for benefits under the policy. When making a benefit determination, we will have discretionary authority to interpret the terms and provisions of the policy. This discretionary authority should not be construed to limit the legal action that may be taken by an insured or beneficiary in accordance with the Legal Actions provision of the policy and any applicable state or federal law.

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.

CHANGE OF BENEFICIARY

The right to change a Beneficiary is reserved to the Subscriber and the consent of the Beneficiary, or beneficiaries, shall not be requisite to surrender or assignment of this policy or to any change of Beneficiary, or beneficiaries, or to any other changes in this policy.

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 Florida Department of Labor, 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 Florida Department of Labor. 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 Florida 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

Recoveries from Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, Provider and/or Hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. 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.

UNPAID PREMIUMS

If there is any premium due and unpaid at the time We pay a claim under this policy, We may deduct the amount due from Our payment of the claim.

LIMITATION OF LEGAL ACTION

No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy that, on its Effective Date, is in conflict with the laws of the state in which the insured resides on that date is amended to conform to the minimum requirements of such laws. 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 Florida Office of Insurance Regulation.

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.

GRACE PERIOD

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 last day for which You have paid Your premium.

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.

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.

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 Florida. To the extent that state law applies, the laws of the State of Florida 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

TERMINATION BY THE PLAN

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

In the event of non-payment of premium, we will provide You with at least ten (10) days advanced written notice before cancelling your policy.

If We terminate Your coverage with Us or through the Exchange, we will provide you with a notice of termination that includes the termination effective date and the reason for termination.

- If we terminate Your coverage due to the circumstances listed below, , We will provide You with at least forty-five (45) days advanced written notice prior to the termination of Your coverage. 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 Florida. 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.
- For Individual Policies (not Child-Only): An Enrolled Dependent Child reaches age 26. If the Dependent child is incapable of self-sustaining employment by reason of intellectual or physical disability and is chiefly dependent upon the policyholder for support and maintenance, the Dependent can remain as a Dependent Child under the Policy. Proof of such dependency may be required within 31 days of the child's attainment of the limiting age, but not more frequently than annually.
- 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 last day for which You have paid Your premium. 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.
- In the event of fraud, including improper use of Your ID card or intentional misrepresentation

of material fact, We will provide You with thirty (30) days written notice prior to rescinding coverage. 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.

TERMINATION BY THE EXCHANGE

The Exchange may initiate termination of Your Policy with Us in the following circumstances:

- You are no longer eligible for coverage through the Exchange.
- You have not paid Your premiums and any applicable Grace Period has been exhausted.
- Your coverage is rescinded after We demonstrate the rescission is appropriate due to an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited under this Policy. If Your coverage is being rescinded, You will receive at least 30 days advance written notice.
- You select coverage in a different plan during the annual Open Enrollment Period.
- You select coverage in a different plan during a Special Enrollment Period.
- You were enrolled in a plan by a third party, without Your consent or knowledge.

If Your coverage is being terminated by the Exchange You will receive a notice of termination that includes the termination effective date and the reason for termination.

TERMINATION AT YOUR REQUEST

You have the authority to terminate Your Policy. If You wish to end Your coverage, We must 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 retroactive terminations, 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.

CONTINUATION

A Covered Person has the right to continue coverage if his or her eligibility under this Policy would terminate due to:

- the Subscriber's death;
- divorce;
- no longer qualifying as a dependent under the Policy; or
- if a Covered Person's eligibility for coverage under this Policy terminates prior to that Covered Person being eligible for Medicare or Medicaid benefits.

Coverage will be continued if the Covered Person notifies Us within 31 days following the date the Policy would otherwise terminate, and pays the appropriate monthly premium. No evidence of insurability is required to continue coverage.

Section 13 - Appeals and Grievances

APPEALS AND GRIEVANCES

You may have a concern with Your policy or be dissatisfied with quality of care, a service issue, or the denial of a claim or request for service that You had. Dissatisfaction with quality of care or service may be filed as a grievance. Dissatisfaction with the denial of a claim or request for service may be filed as an appeal. Below is a brief description of each process.

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 GRIEVANCE

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 grievance 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 grievance.

DENIAL OR ADVERSE DETERMINATION

If We deny a claim for health care services under this plan, We will send written notification of the denied claim to You and to the Participating Provider that submitted the claim if the health care provider would otherwise be eligible for payment. If the services being denied were received from a Non-Network Provider, We will send You written notification of the denied claim.

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.

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.

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 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 six (6) 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. 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 independent external review. We will notify You of

the review entity selected by 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 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, and Us. 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 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. 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 Independent External Review Organization within one (1) working day of receiving the request. We will notify You of the review entity 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, 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 Florida Office of Insurance Regulation.

Florida Office of Insurance Regulation
Email: InsuranceCommissioner@floir.com
Phone: (850) 413-3140

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. We will notify You at least forty-five days in advance prior to a premium increase taking effect.

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.

OTHER INSURANCE WITH THIS INSURER

If while covered under this Policy, You are also covered by another individual Policy issued by Us, You be entitled to the benefits of only one Policy. You may choose this Policy or the Policy under which You will be covered. We will then refund any premium received under the other Policy covering the time period both policies were in effect.

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

Section 15 - Definitions

Accident or **Accidental Injury** means an unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic injury. This does not include injuries caused by surgery or treatment for a disease or illness.

Accidental Dental Injury means an injury to sound, natural teeth (not previously compromised by decay) caused by a sudden, unintentional, and unexpected event or force.

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.

Allowed 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.

For Covered Health Services received When receiving care from a Non-Network Provider at a Non-Network facility and which have been Pre-Authorized by Us, Our Allowable Amount is 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 if We are unable to negotiate an amount with the Non-Network Provider, Our Allowable Amount will be 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, 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 the Subscriber's or covered Spouse's natural, newborn, adopted, foster or stepchild (or a child for whom the Subscriber or covered Spouse has been court-appointed as legal guardian or legal custodian) who has not reached the end of the calendar year in which he or she reaches age 30, regardless of the dependent child's student or marital status, financial dependency on the covered parent, whether the dependent child resides with the covered parent, or whether the dependent child is eligible for or enrolled in any other health plan.

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.

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 Healthcare.gov - 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 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”; and
- Performed 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.

Registered Nurse means a person properly licensed to practice professional nursing pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law of another state.

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.

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. 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 Out-of-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.