



2020 Certificate of Coverage

BrightHealthPlan.com

Section 1 - Schedule of Benefits
Gold 2 Plan
(Who Pays What)
Plan Effective Date: January 1, 2020

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
- We authorize services out-of-network because the Medically Necessary services that You need are not available from a Network Provider.

You can review our provider network online at www.brighthealthplan.com, or You can contact Bright Health Plan Customer Service at (855) 521-9349.

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 Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 to locate a provider.

SERVICE	PLAN LIMITATIONS	IN-NETWORK	NON-NETWORK
Physician Services	For additional information regarding Allergy Services, please refer to p. 49 - Physician's Services for Sickness and Injury.	\$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 Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 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 Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 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

Bariatric Surgery

Bariatric Surgery must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 to locate a provider.

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

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Chemotherapy and Radiation Treatment

Chemotherapy and Radiation treatment must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 to locate a provider.

SERVICE	PLAN LIMITATIONS	IN-NETWORK	NON-NETWORK
Chemotherapy or Radiation Treatment	Services require pre-authorization.	20% after deductible	Not covered

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 Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 to locate a provider.

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

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Dialysis Services

Dialysis treatment must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 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 Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 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 and Urgent Care Services received from Non-Network Providers will be covered at the In-Network benefit level. Payment to the Non-Network Provider will be based on Our Allowable Charge. Non-Network Providers may bill you for charges that exceed Bright Health's allowed charges.

SERVICE	PLAN LIMITATIONS	IN-NETWORK	NON-NETWORK
Emergency Room Services (Facility charges)	In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help.	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)	Urgent Care is for the treatment of an illness or injury that requires care right away, but is not serious enough to require an emergency room visit.	\$75 per visit	\$75 per visit
Urgent Care Center Services (Ancillary charges)		20% after deductible	20% after deductible

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Genetic Testing and Counseling

Genetic Testing and Counseling Services must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 to locate a provider.

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

Hearing Services

Hearing Services must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 to locate a provider.

SERVICE	PLAN LIMITATIONS	IN-NETWORK	NON-NETWORK
Hearing Exam and Testing	Limited to 1 screening per year to detect the need for hearing correction.	20% after deductible	Not covered
Hearing Aids	Limited to members under age 22; Plan will cover the one hearing aid per hearing impaired ear every 36 months.	20% after deductible	Not covered

Home Health Care

Home Health Care Services must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 to locate a provider.

SERVICE	PLAN LIMITATIONS	IN-NETWORK	NON-NETWORK
Home Health Services	Services require pre-authorization.	20% after deductible	Not covered

Hospice Care Services

Hospice Care must be received from a Participating Bright Health Plan hospice facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 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	See Outpatient Mental Health & Substance Abuse Services	\$50 per visit	Not covered

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Hospital Services

Services must be received from a Participating Bright Health Plan hospital facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 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
Skilled Nursing Facility	Limited to 60 days per year; Services require pre-authorization.	20% after deductible	Not covered

Infertility Services

Infertility Services must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 to locate a provider.

SERVICE	PLAN LIMITATIONS	IN-NETWORK	NON-NETWORK
Diagnosis and Management	Coverage includes services for diagnosis and treatment of involuntary infertility. Services require pre-authorization.	20% after deductible	Not covered
Treatment for Infertility	Services to reverse voluntary sterilization or infertility are not covered. Services require pre-authorization. Limited to 3 treatments per lifetime.	20% after deductible	Not covered

Infusion Therapy

Infusion Therapy Services must be received from a Participating Bright Health Plan provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 to locate a provider.

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

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Lab, X-Ray and Diagnostic Services

Diagnostic services must be received from a Participating Bright Health Plan provider, hospital or outpatient facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 to locate a provider.

SERVICE	PLAN LIMITATIONS	IN-NETWORK	NON-NETWORK
Diagnostic Outpatient Laboratory & Radiology & Testing	For additional information regarding Lab, X-Ray and Diagnostic Services, please refer to p. 45.	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 Plan provider or facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 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 Plan Customer Service at (855) 521-9349 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 <i>Medically necessary orthodontia and prosthodontics</i>			

Pediatric Vision Services

Pediatric Vision Services are available for dependent children under 19 years of age. Services and must be received from a Participating Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 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 Plan Customer Service at (855) 521-9349 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 Plan Customer Service at (855) 521-9349 to locate a provider.

SERVICE	PLAN LIMITATIONS	IN-NETWORK	NON-NETWORK
Primary Care Office Visits	For diagnostic lab or x-ray services, deductible and coinsurance apply. Hospital-owned clinics may charge a "clinic fee". These charges will apply deductible and coinsurance.	\$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)	Hospital-owned clinics may charge a "clinic fee".	20% after deductible	Not covered

Pregnancy - Maternity Services

Maternity services must be received from a Participating Bright Health Plan provider or facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 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) 521-9349.

SERVICE	PLAN LIMITATIONS	RETAIL IN-NETWORK	MAIL ORDER IN-NETWORK	NON-NETWORK
<i>Preventive Medications and Formulary Contraceptive Medications and Devices (Tier 1)</i>	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
<i>Generic (Tier 2)</i>		\$10 per prescription	\$25 per prescription	
<i>Preferred Brand (Tier 3)</i>		\$50 per prescription	\$125 per prescription	
<i>Non-Preferred Brand (Tier 4)</i>		20% after deductible	20% after deductible	
<i>Specialty Medications (Tier 5)</i>		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 Plan Customer Service at (855) 521-9349 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 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	

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Prosthetics

Prosthetic Devices must be received from a Participating Bright Health Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 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 Plan Customer Service at (855) 521-9349 to locate a provider.

SERVICE	PLAN LIMITATIONS	IN-NETWORK	NON-NETWORK
Occupational Therapy	Limited to 30 combined visits per year for Occupational Therapy, Physical Therapy, and Chiropractic Manipulations. No therapy limitation for Occupational and Physical Therapy services for the treatment of autism.	20% after deductible	Not covered
Physical Therapy		20% after deductible	Not covered
Chiropractic Manipulations		20% after deductible	Not covered
Speech Therapy	Limited to 30 visits per year.	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 Plan Customer Service at (855) 521-9349 to locate a provider.

SERVICE	PLAN LIMITATIONS	IN-NETWORK	NON-NETWORK
Sleep Studies	Services require pre-authorization.	20% after deductible	Not covered

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Temporomandibular Joint Disorder Treatment

Services for the treatment of Temporomandibular Joint Disorder must be received from a Participating Bright Health Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Plan Customer Service at (855) 521-9349 to locate a provider.

<i>SERVICE</i>	<i>PLAN LIMITATIONS</i>	<i>IN-NETWORK</i>	<i>NON-NETWORK</i>
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 Plan Customer Service at (855) 521-9349 to locate a Participating Provider or Facility.

<i>SERVICE</i>	<i>PLAN LIMITATIONS</i>	<i>IN-NETWORK</i>	<i>NON-NETWORK</i>
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.

<i>SERVICE</i>	<i>PLAN LIMITATIONS</i>	<i>YOUR COST</i>
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 Company of North Carolina, 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 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 except as described in Section 6 - How to Access Your Services and Obtain Approval of Benefits.

Entire Contract

In addition to this Evidence of Coverage, this Policy includes Your:

- Schedule of Benefits
- enrollment application

The documents above make up the entire legal contract between Bright Health and You, the Subscriber. Read Your Policy carefully.

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

How to Use this Document

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

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

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

Ten Day Right to Return Policy

Read your policy carefully. If for any reason you are not satisfied with your policy, you may return it to Us within 10 days of the date you received it and the premium you paid will be promptly refunded. Your Policy will be considered null and void from the effective date.

Important Cancellation Information – Please read Section 12 - Termination/Nonrenewal/ Continuation found on page 90 of the policy.

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

A handwritten signature in black ink, appearing to read 'Bob Sheehy', with a stylized flourish at the end.

Bob Sheehy
Chief Executive Officer

Section 3 - Contact Us

Please contact Us for more information.

Questions About Your Benefits

Customer Service:
(855) 521-9349

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) 521-9349.

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) 521-9349.

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) 521-9349]。

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) 521-9349.

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) 521-9349로 전화하십시오.

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) 521-9349.

Arabic

فلديك الحق في الحصول على المساعدة والمعلومات، إن كان لديك أو لدى شخص تساعد أسئلة بخصوص
الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ (855) 521-9349.

Hmong

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Bright Health, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau (855) 521-9349.

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) 521-9349.

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) 521-9349.

Gujarti

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યા છો તેમ જો કોઇને [એસબીએમ ક યકમન ાં ન મ મ કો] વિશે પ્રશ્નો ઊર્ તો તમને મદદ અને મ ઉત્તરી મેળિં નો અવિક ર છે. તે અર્થ વિન તમ રી ભ ષ મ ાં પ્ર મ કરી શક ર છે. દ ભ વર્ણો િ ત કરિ મ ટે, આ [અર્થી દ બલ કરો નાંબર] પર કોલ કરો.

Mon-Khmer, Cambodian

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ម្ចាស់សំណួរអំពី Bright Health ឬ, អ្នកម្ចាស់សិទ្ធិណែនាំជំនួយនិងព័ត៌មាន ជាក់ស្តែងសា រស់អ្នក ដោយមិនអ្វីប្រាក់ ។ បើមិនបីនិយាយជាមួយអ្នករកដប្ប សូម (855) 521-9349 ។

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) 521-9349 an.

Hindi

यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Bright Health के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िभाषण से बात करने के लिए ,(855) 521-9349 पर कॉि करें।

Laotian

ຖ້າທ່ານ, ຫຼື ຄົນ ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີ ຄຳຖາມກ່ຽວກັບ Bright Health, ທ່ານມີ ສິດທິ ທ່ານຈະໄດ້ຮັບການຊ່ວຍເຫຼືອ ທ່ານແລະຂໍ້ມູນຂ່າວສານ ທ່ານ ບໍ່ເປັນພາສາຂອງທ່ານ ບໍ່ມີ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ນລັກກັບພາສາ, ໃຫ້ໂທຫາ (855) 521-9349.

Japanese

ご本人様、またはお客様の身の回りの方でも、Bright Healthについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(855) 521-9349までお電話ください。

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Section 5 - Eligibility

We offer two types of Individual policies:

1. Individual Policies that cover at least one adult age 19 or older. This type of Policy may also include coverage for eligible Dependents.
2. Individual Child-Only Policies that cover children under age 21. This type of Policy does not have 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; and
- 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, *except in the case of a child-only Policy*, that resides within the Service Area and meets the criteria of Spouse as stated in the *Definitions section of this Policy*.
- Your Child(ren) as defined in the *Definitions section of this Policy*.

When a Dependent is 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 a special enrollment period as described below. A special enrollment period is a period of time when enrollment is allowed before or after a person becomes eligible for coverage.

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. Coverage will begin 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;
- A court orders that You cover a current spouse or minor child onto Your policy;
- The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by state law, or if the Enrollee, or his or her dependent, dies;
- 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 Medicaid or an S-CHIP plan;
- An individual becoming ineligible under the North Carolina Medicaid Program;
- An individual, who was not previously a citizen, a national, or a lawfully present individual, gains such status;
- 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;
- An individual demonstrates to the Exchange, in accordance with guidelines issued by the US Department of Health and Human Services, that the individual meets other exceptional circumstances as the Exchange may provide;
- An individual or enrollee:
 - is a victim of domestic abuse or spousal abandonment, including a Dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or
 - is a Dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;
- An individual or dependent:
 - applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event; or
 - applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;

- An individual or Dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the decision to purchase a plan through the Exchange; or
- At the option of the Exchange, the individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Exchange following termination of Exchange enrollment due to a failure to verify such status within a specified time period or is under 100 percent of the Federal poverty level and did not enroll in coverage while waiting for verification of citizenship, status as a national, or lawful presence.
- Any other event or circumstance occurs as set forth in rules from the North Carolina Department of Insurance that defines triggering events.

If You know that a qualifying event is going to occur, 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.

Enrollment of Newly Eligible Dependent

A Subscriber must submit an Enrollment Application requesting coverage for Dependents who become eligible after the original Policy effective date. The Subscriber will be notified of coverage approval, the amount of required Premium payment, and the effective date of coverage for the Dependent.

A newborn dependent child of the Subscriber is automatically covered for the first 30 days of life. If You wish to continue enrollment of the newborn beyond the 31st day, You must enroll the newborn 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 within 31 days of the date of birth. Newborn Premiums are not pro-rated.

For newly adopted children (including children newly placed for adoption) and foster children, the effective date of coverage is the date of the adoption or placement for adoption, or the placement for foster care. An eligible adopted child must be enrolled within 30 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 within 30 days of the adoption or placement for adoption. The monthly Premium for the newly adopted child is the entire month's Premium. Adopted child Premiums are not pro-rated.

If We require any Premium and/or written documentation to support the effective date of the qualifying event, it must be submitted with the application. Proof of the qualifying event may be a copy of the marriage certificate, or a Qualified Medical Support Order, or other documentation. The documentation must be attached to the completed application.

If a Dependents is not enrolled when they first become eligible, the Dependent 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.

Custodial Parent

This provision applies if the parents of a covered eligible child are divorced or legally separated and both the custodial parent and the non-custodial parent are subject to the same court or administrative order establishing custody. The custodial parent, who is not a member, will have the rights stated below if we receive a copy of the order establishing custody.

Upon request by the custodial parent, we will:

- Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions, and limitations of the policy;

- Accept claim forms and requests for claim payment from the custodial parent; and
- Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge our obligations.

A custodial parent may, with our approval, assign claim payments to the hospital or medical practitioner providing treatment to an eligible child.

Change in Status – Notice Required

The Subscriber is responsible for notifying Us or the Exchange of any changes that affect eligibility for services under this Policy. Changes may be on the Subscriber's or enrolled Dependent's eligibility. The Subscriber must notify Us or the Exchange within 60 days of the event. This includes changes of address, addition or deletion of dependents resulting from death, achieving the limiting age, and changes in Dependent Disability or Dependent status. Coverage for ineligible members will terminate in accordance with the termination provisions described in this Policy.

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

Covered Health Services

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

THIS IS A NETWORK-ONLY PLAN

This plan uses 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
- We authorize services out-of-network because the Medically Necessary services that you need are not available from a Network Provider.

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

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. It will also determine 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 go through a credentialing process. During credentialing, either We or Our designees confirm public information about the Provider's licensure and other professional credentials. This 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.

With this plan You have direct access to eye care providers, mental health care providers, pediatricians, and obstetrical or gynecological health care professionals. You do not need a referral from the plan or from any other person (including a primary care provider) to receive care from a Specialist in Our network. Specialists focus on specific areas of medicine to diagnose, manage, prevent or treat certain types of symptoms and conditions. The Specialist may be required to comply with certain provisions related to obtaining Pre-authorization or following a pre-approved treatment plan. For a list of participating Specialists, visit Our website at www.brighthealthplan.com or call Customer Service at the number listed in *Section 3* of this *Policy* and on Your ID card.

Services from Non-Network Providers are not covered except:

- Emergency Medical Conditions;
- You are treated by a Non-Network Provider while you are receiving care at a Network facility; or
- 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 receive care from a Non-Network Provider for non-Emergency Medical Conditions without Pre-authorization from Us, You will be responsible for the entire amount that the Provider bills.

Provider Network

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

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. If you feel you qualify for Continuity of Care, you must apply within 45 days of Your Network Provider leaving Our Network. For information on how to apply for Continuity of Care, contact Bright Health Plan Customer Service at (855) 521-9349.

Choosing a Primary Care Physician

When You enroll with Us, You must choose a Primary Care Physician (PCP). Any covered Dependents also must choose a PCP. If You do not select a PCP, we will assign one for You. If Your PCP ceases to be a Participating Physician, You will be able to choose a new PCP. You may change Your PCP once per calendar month. We reserve the right to determine the number of times during a Plan Year that You will be allowed to change Your PCP.

Members diagnosed with a serious or chronic degenerative, disabling, or life-threatening disease or condition, either of which requires specialized medical care may designate a specialist, with expertise in treating the disease or condition, as their Primary Care Physician. If We determine that care would not be appropriately coordinated by the designated specialist, We may deny access to that specialist as a primary care provider.

Transition of Care

Transition of Care allows you to continue to receive specific medical and behavioral care 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.

If You have an acute medical condition, Your Transition of Care period will not be more than 90 days after the effective date of the enrollment.

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

- Pregnancy, in the second 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.
- a life-threatening disease or condition.

If You have entered the second trimester of pregnancy on the date You received notice of the Provider's termination, and the provider was treating the pregnancy before the date of the notice or the date of enrollment in the new plan, You are eligible for Continuity of Care with respect to the Provider's treatment of the pregnancy through the pregnancy and for 60 days of postpartum care. 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

You must apply for Transition of Care at enrollment, or change in your Health plan, but no later than 90 days after the effective date of your coverage.

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) 521-9349.

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 45 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:

- Scheduled Surgery, Organ Transplantation, or Inpatient Care – If surgery, organ transplantation, or other inpatient care was scheduled before the date You received notice of the Provider's termination or if at the time of enrollment in the Plan You are on an established waiting list or otherwise scheduled to have the surgery, transplantation, or other inpatient care, You shall be eligible for Continuity of Care for up to 90 days after the date of discharge.
- Terminal Illness – If You are terminally ill at the time of a Provider's termination under the Plan, or if at the time of enrollment in the Plan a provider was treating the terminal illness before the date of the termination or enrollment in the plan, You are eligible for Continuity of Care for the remainder of the Your life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

Pregnancy – If You have entered the second trimester of pregnancy on the date You received notice of the Provider's termination, and the provider was treating the pregnancy before the date of the notice or the date of enrollment in the new plan, You are eligible for Continuity of Care with respect to the Provider's treatment of the pregnancy through the pregnancy and for 60 days of postpartum care. 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) 521-9349.

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 Bright Health Plan Customer Service at (855) 521-9349 if you wish to review these policies.

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 will reimburse You according to the Travel Expenses provision of this Policy.

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.

Receiving Non-Emergent Care From Non-Network Providers

There are specific situations when this Plan will cover non-emergency 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, or call Us at (855) 521-9349.

Pre-Authorized Care From Non-Network Providers

In a case where We do not have a Participating Provider or specialist within the 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.

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 submit the claim or itemized bill to Us.

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 where Covered Health Services are generally available and accessible to You and Your covered Dependents from Network Providers. Your Service Area includes Mecklenburg, Union, Cabarrus, Rowan, Gaston, Forsyth, Davidson, Stokes, Davie and Yadkin counties.

Services from Network Providers can be accessed anywhere in Your Service Area. Services received outside of Your Service Area from a Non-Network Provider, with the exception of care for Emergency Medical Conditions, will not be covered. Care for Emergency Medical Conditions will be covered regardless of the provider's Network status or if You were in the Service Area.

Care for Non-Emergency Medical Conditions received from Non-Network Providers or received outside of Your Service Area will not be covered unless you have Pre-authorization from Us.

Please refer to the provider directory on Our website at ***www.brighthouseplan.com*** for a list of Network Providers in Your Service Area. You can also contact *Customer Service* 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 certain information to make decisions about medical necessity.

For new interventions, effectiveness is based on the scientific evidence.

For existing interventions, effectiveness is determined by:

- scientific evidence;
- professional standards;
- expert opinion; and
- the consideration of cost-effectiveness compared to alternative interventions, including no intervention.

Pre-authorization

Pre-authorization is the process of reviewing a request for health care services to make sure they are Medically Necessary, and that the Provider is In-Network prior to You receiving care.

Who is responsible for obtaining Pre-authorization?

If You are receiving care from a Network Provider, the Provider is responsible for obtaining Pre-authorization before You receive care. If the Provider does not receive Pre-authorization and the service is denied, he or she is not allowed to bill You for those services.

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 in place. Information regarding the services can come from the Non-Network Provider or from You.

Through the Pre-authorization process, You may qualify for specialty programs, which may 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 Your 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:

- Accidental Dental Services
- Acute Rehabilitation services
- Applied Behavioral Analysis
- Autism/Autism Spectrum Disorder Treatment
- Bariatric Surgery
- Behavioral Health/Substance Abuse (Mental/Nervous/Chemical/Alcohol Dependency)
 - Inpatient Facility
 - Inpatient Rehabilitation
 - Partial Hospitalization
 - Intensive Outpatient Treatment
 - Outpatient Detoxification
- Chemotherapy
- Clinical Trials
- Colonoscopy
- Custom Shoes for Diabetics
- Dialysis, Hemodialysis and Peritoneal Dialysis
- Durable Medical Equipment
- Enteral Nutrition
- Genetic testing and counseling
- Hearing Aids
- Home Health Care
- Home Infusion Therapy
- Hospice
- Hospital admission (Inpatient or Observation). If You are admitted for an emergent inpatient medical or surgical hospitalization, You or Your provider must notify Us within 23 hours of the

admission, or as soon as reasonably possible. If Your hospitalization is non-urgent, Your provider must request Pre-authorization at least 5 business days before the scheduled admission or procedure.

- Hyperbaric Oxygen
- Infertility Testing or Treatment
- Infusion Therapy
- Inpatient Habilitation or Rehabilitation Facility
- Inpatient Hospital stay in excess of 48 hours for the mother and newborn child following a normal vaginal delivery and in excess of 96 hours for the mother and child following a cesarean section delivery
- Insulin Pumps
- Joint Procedures, including but not limited to joint replacement, joint reconstruction and joint injections
- Low vision services
- 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
- Private Duty Nursing
- Radiation Therapy, including gamma knife
- Reconstructive Services
- Sick newborn nursery care
- Skilled Nursing Facility
- Sleep Studies
- Spine Care relating to neck and back conditions, including:
 - surgery,
 - epidurals,
 - facet and trigger point injections,
- Surgery
 - Inpatient
 - Outpatient
 - Ambulatory
 - Cyber Knife/ASC
 - Intraoperative Monitoring including Surgical Neuromonitoring
- Temporomandibular Joint Dysfunction treatment
- Therapeutic injections
- Transplants and transplant related services (including pre and post transplant testing)
- Upper Gastrointestinal (GI) Endoscopy
- 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. Pertinent information includes the results of any patient examination, clinical evaluation, or second opinion that may be required.

Prospective and Concurrent Prior-authorization Review

Prospective and concurrent Prior-authorization determinations shall be communicated to Your Provider within three (3) business days after We receive all necessary information about the admission, procedure, or health care service. If We authorize a health care service, We shall notify the Your Provider. For an Adverse Determination or Denial of the Pre-authorization request, We shall notify Your Provider and send written or electronic confirmation of the Denial to You. For

concurrent reviews, We shall remain liable for health care services until You have been notified of the Adverse Determination.

Retrospective Reviews

For retrospective review determinations, We shall make the determination within 30 days after receiving all necessary information. For a certification, We may give written notification to the Your Provider. For an Adverse Determination or Denial of the Pre-authorization request, We shall give written notification to You and Your Provider within five (5) business days after making the determination.

We must make Our determination 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 determination. 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.

Coverage Determinations

If We determine that services, supplies, or other items are covered under this plan, including any Pre-authorization Determinations as described above, We shall not subsequently retract Our determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the patient's health condition that was knowingly made by the insured or the provider of the service, supply, or other item.

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. Through Care Management We may provide You with information about additional services available to You, such as disease management programs, health education, and patient advocacy.

All Care Management decisions are made by qualified licensed professionals who are 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 the existence of coverage. 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 your Schedule of Benefits for Coinsurance Percentage and other limitations.

The amount provided or payable will be subject to:

- Any specific benefit limits stated in the policy; and
- A determination of eligible service expenses.

The applicable Deductible amount(s), Coinsurance percentage, and Copayment amounts are shown on the Schedule of Benefits.

NOTICE: Your actual expenses for Covered Services may exceed the stated coinsurance percentage or copayment amount because actual Provider charges may not be used to determine policy and member's payment obligations.

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 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 Our reimbursement policy guidelines:

- 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. You will be responsible for your plan's copayment, deductible or coinsurance amounts. Often times You will receive a bill for Your portion of the payment after you have already received care. If this happens, We encourage You to contact Customer Service, check your Explanation of Benefits (EOB) or login to Your Member Hub to ensure the bill you receive does not exceed the amount You owe according to Your Explanation of Benefits.

Our reimbursement policies are available for review. To obtain a copy of Our reimbursement policies, contact Bright Health Plan Customer Service at (855) 521-9349.

Explanation of Covered Health Services

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

- Services or supplies are Medically Necessary and for the purpose of diagnosing or treating a Sickness, Injury, or associated symptoms, unless otherwise specified
- Covered Health Services are received while this Policy is in effect
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in the *Termination/Nonrenewal/Continuation Section of this Policy*
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in this Policy.

This section describes Covered Health Services for which Coverage is available. Please refer to

the *Schedule of Benefits (Who Pays What)* section of this Policy for details about:

- The amount You must pay for these Covered Health Services (including any Annual Deductible, Copayment, and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day, and dollar limits on services).
- Any limit that applies to the amount You are required to pay in a calendar year (Out-of-Pocket Maximum).

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

All Covered Health Services are subject to the terms and conditions of this Policy, including any limitations or exclusions 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 the services require Pre-Authorization.

Accident Related Dental Services

Outpatient Services, physician Home Visits and Office Services, care for Emergency Medical Conditions and Urgent Care services received 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. "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 6 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;
- Diagnostic radiography;
- 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

This Plan covers Emergency Ambulance Transportation Services by ground, air or water. Services must be provided by a licensed ambulance service provider. Ambulance transport services are intended to take a Covered Person to the nearest Hospital where care for Emergency Medical Conditions can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground, air or water ambulance) is covered between facilities **only** when the transport is one 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.

Coverage for Applied Behavioral Analysis is limited to Covered Persons through age 18.

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

Bariatric Surgery

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

Bone Mass Measurement for Diagnosis and Evaluation of Osteoporosis or Low Bone Mass

Covered Health Services under this benefit include services for bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass. Bone mass measurement will be covered if at least 23 months have elapsed since the last bone mass measurement was performed, except that We will provide coverage for follow-up bone mass measurement performed more frequently than every 23 months if the follow-up measurement is Medically Necessary. To qualify for coverage of this benefit, one or more of the following criteria must be satisfied:

- An individual is estrogen-deficient and at clinical risk of osteoporosis or low bone mass;
- An individual has radiographic osteopenia anywhere in the skeleton;
- An individual is receiving long-term glucocorticoid (steroid) therapy;
- An individual has primary hyperparathyroidism;
- An individual is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;
- An individual has a history of low-trauma fractures; or
- An individual has other conditions or on medical therapies known to cause osteoporosis or low bone mass.

Chemotherapy Services - Outpatient

This Plan will cover 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.

Circumcision of Newborn Males

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

Cleft Lip and Cleft Palate Treatment

This Plan covers services related to treatment for Cleft Lip and Cleft Palate. Services must be provided by or under the direction of a Physician. Covered Health Services include:

- 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 subject to limitations in the Schedule of Benefits.
- 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;
- Any 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

this state 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 has been reviewed and approved by an institutional review board of an institution in this state.
- (C) The personnel providing the treatment or conducting the study:
 - (i) Are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise.
 - (ii) Agree to accept reimbursement as payment in full from the health care services organization at the rates that are established by the organization and that are not more than the level of reimbursement applicable to other similar services provided by health care providers with the organization's provider network.
- (D) There is no clearly superior, non-investigational treatment alternative.
- (E) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as any non-investigational alternative.

"Routine patient care cost" means all items and services that are a benefit under a health coverage plan that would be covered if 1) the Covered Person were not involved in either the experimental or the control arms of a clinical trial; except the investigational item or service, itself; 2) items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; 3) items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; 4) items or services that are typically provided absent a clinical trial; 5) items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and 6) items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

Congenital Defect and Birth Abnormalities

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

Physical, and occupational therapy for the care and treatment of congenital defect and birth abnormalities are covered. Short-term outpatient rehabilitation services are limited to sixty (30) visits per calendar year combined between physical therapy and occupational therapy. Speech therapy is covered and limited to 30 visits per calendar year. Therapy visits may be distributed as medically appropriate throughout the yearly term of the Policy without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

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

Dental Anesthesia

Facility and anesthesia services for hospitalization in connection with dental or oral surgery will be covered, provided that the confinement has been pre-authorized because of a hazardous medical condition. Such conditions include heart problems, diabetes, hemophilia, dental extractions due to cancer related conditions, and the probability of allergic reaction (or any other condition that could increase the danger of anesthesia).

Covered Health Services under this section also include general anesthesia for children under 19 years of age, persons who are physically or mentally disabled, and persons with significant behavioral problems, where the provider treating the patient involved certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures. The same deductibles, coinsurance, Medical Necessity provisions, and other limitations that apply to physical illness benefits under this plan shall apply to coverage for anesthesia and hospital or facility charges. All facility services must be provided by a contracted network provider.

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.
- Podiatric appliances for prevention of complications associated with diabetes; foot orthotic devices and inserts (therapeutic shoes: including Depth shoes or Custom Molded shoes.) Custom molded shoes will only be covered when the member has a foot deformity that cannot be accommodated by a depth shoe. Therapeutic shoes are covered only for diabetes mellitus and *any* of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation.
- Elastic stockings.
- Insulin pumps and supplies used conjunction with the insulin pumps.

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

Dialysis Services - Outpatient

This Plan covers dialysis treatments received on an outpatient basis. Dialysis may be received 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 but are not limited to:

- Equipment to assist mobility, such as a standard wheelchair
- A standard Hospital-type bed
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors, and masks).
- Delivery pumps for tube feedings
- Urinary catheters and associated equipment
- 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 Durable Medical Equipment solely for warranty expiration, or new and improved equipment becoming available is not covered. Duplicate or extra Durable Medical Equipment for the purpose of the member's comfort, convenience, or travel is not covered. Durable Medical Equipment Benefits do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body as such services are covered under the Prosthetic Devices provisions of this Policy

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 Medical Conditions

Covered Health Services under this section include services required to 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.

All Covered Health Services for Emergency Medical Conditions will be reimbursed according to Network reimbursement policies, regardless of the Network status of the billing provider.

If You are admitted to a Non-Network facility through the emergency department, 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 department 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 Medical Condition.

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.

Pre-Authorization is required for Genetic Testing services.

Routine physical measurements, blood chemistries, blood counts, urine analyses, tests for abuse of drugs and tests for the presences of human immunodeficiency virus are not considered genetic tests.

Hearing Services & Hearing Aids

The Plan will cover hearing screenings to determine the presence of hearing loss and/or diagnose and treat a suspected disease or injury to the ear.

For Covered Persons under the age of 22, coverage also includes one hearing aid per hearing impaired ear every thirty-six (36) months. Hearing loss must be verified by a licensed Physician or by an audiologist. The hearing aids shall be medically appropriate to meet the needs of the member according to accepted professional standards. Coverage shall include the purchase of the following, limited to the least expensive professionally adequate device:

- Initial hearing aids and replacement hearing aids not more frequently than once per thirty-six (36) month period;
- A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the member;
- Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

We have a list of approved hearing devices and may authorize other models at an equivalent dollar value to allow for changing technology. Please contact Us for the list of approved devices.

High Tech Diagnostic Imaging, Nuclear Medicine, and Major Diagnostic Services - Outpatient

This Plan covers CT scans, PET scans, MRI, MRA, BEAM (Brain Electrical Activity Mapping) nuclear medicine, or major diagnostic services received on an outpatient basis at a Hospital, Alternate Facility.

Coverage includes charges for the facility, supplies and equipment, and physician services.

Home Health Care

This Plan will cover services received from a Home Health Agency that is ordered by a Physician, and provided in Your home by a certified home health agency.

Coverage is available only when the 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 apply:

- Care is 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.
- Care is ordered by a Physician.
- Care 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.
- Care requires clinical training in order to be delivered safely and effectively.
- The care provided 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.

Hospice Care

This Plan covers hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill.

Care must be 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 covered under this Policy. Short-term grief counseling must be received 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 treatment at an emergency room.

Inpatient hospital services are services provided for evaluation or treatment of conditions that cannot be adequately treated on an outpatient basis or in another Participating facility. Services include semi-private room and board; care and services in an intensive care unit; drugs, medications, biologicals, fluids, blood and blood products, and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; laboratory and radiology services and other diagnostic and therapeutic services; anesthesia and associated services; inhalation therapy; radiation therapy; admit kit; and other services which are customarily provided in acute care hospitals. Inpatient hospital services also include Birthing Centers.

Outpatient facility services are services provided on an outpatient basis, including diagnostic and/or treatment services; administered drugs, medications, fluids, biologicals, blood and blood products; inhalation therapy; and procedures which can be appropriately provided on an outpatient basis, including certain surgical procedures, anesthesia, and recovery room services.

Care for Emergency Medical Conditions include the facility, 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.

Immunizations

Covered immunizations for adults and children over age 2 include:

- Influenza, Trivalent inactivated influenza vaccine (TIV)
- Influenza, Live attenuated influenza vaccine (LAIV)
- Pneumococcal
- Hepatitis A (Hep A)
- Hepatitis B (Hep B)
- Td/Tdap (Tetanus, diphtheria, pertussis)
- Polio (IPV)
- Varicella (Var)
- Meningococcal Conjugate vaccine (MCV4)
- MMR (Measles, mumps, rubella)
- HPV Vaccine
- Shingles Vaccine
- DTap (Diphtheria, tetanus, pertussis)

- Other immunizations approved by the plan.

Covered immunizations will be administered according to guidelines and recommendations from the Centers for Disease Control and Prevention (CDC).

Immunizations are not subject to the annual routine visit limitation.

Infertility Services

Coverage for Infertility includes services provided for the diagnosis, treatment and correction of any underlying causes of infertility, including coverage of certain prescription drugs.

Infertility benefits are limited to three (3) medical ovulation induction cycles per lifetime per member.

Infusion Therapy Services - Outpatient

This Plan covers intravenous infusion therapy treatment received on an outpatient basis at a Hospital or Alternate Facility.

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

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

Benefits under this section include:

The facility charge and the charge for related supplies and equipment. Physician services for anesthesiologists, pathologists, and radiologists.

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

Inpatient Rehabilitative and Habilitative Service

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

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

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

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

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

Lab, X-Ray, and Diagnostic Services - Outpatient

This Plan covers laboratory, x-ray, and radiology services performed for a diagnosis. Services may be provided 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*.

Lymphedema

Covered Health Services under this section include equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be Medically Necessary and is provided by a licensed health care professional whose scope of practice includes the treatment of lymphedema.

Gradient compression garments for treatment of lymphedema are also covered. Gradient compression garments:

- Require a prescription;
- Are custom-fit for the covered individual; and
- Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products

Medical Supplies and Disposable Items

Covered Health Services under this section include disposable medical supplies suitable for use in the home and are required for a course of treatment for a specific medical condition.

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, Intermediate and Residential Treatment

Coverage on this Plan includes care for Mental Health and Substance Abuse Services, including treatment for Biologically-Based Mental Illness, received on an inpatient or Intermediate Care basis. Care may be provided in a general or psychiatric Hospital, a residential treatment center, or an Alternate Facility. Inpatient Stays are covered on a Semi-private Room basis.

Substance abuse detoxification services include detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs, and medication management when provided in conjunction with a consultation. We will determine whether such services will be provided in an inpatient or outpatient setting based on the Medical Necessity of each situation.

Coverage is for 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.

Mental Health and Substance Abuse Services – Outpatient

This Plan covers outpatient care for Mental Health and Substance Abuse Services, including treatment for Biologically Based Mental Illness. Examples of covered services are:

- Mental health, Substance Abuse, and chemical dependency evaluations and assessment;
- Outpatient Electroconvulsive Therapy (ECT);
- Diagnosis;
- Treatment planning;
- Referral services;
- Medication management;
- Outpatient Detoxification;
- Biofeedback
- Short-term individual, family, and group therapeutic services (including intensive outpatient therapy); and
- Crisis intervention.

Outpatient substance abuse services include services for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual, group, structured group or intensive outpatient structured therapy program. Intensive outpatient structured therapy programs consist of distinct levels or phases of treatment that are provided by a certified/licensed substance abuse program. Intensive outpatient structured therapy programs provide nine or more hours of individual, family and/or group therapy in a week.

Coverage is for 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.

This Plan also covers short-term grief counseling for immediate family members covered under this Policy while a Covered Person is receiving Hospice Care.

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,

Nutritional Counseling services specific to achieving or maintaining a healthy weight are covered as Preventive and Wellness Services.

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.

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.

Oxygen and the Oxygen Delivery System

This Plan covers oxygen that is routinely used on an outpatient basis. Coverage is limited to the Plan's Service Area. Oxygen Services and Supplies are not covered outside of the Service Area, except on an emergency basis.

Pediatric Dental Care

We cover the Pediatric Dental services listed below is available for Enrolled Children through the last day of the month in which the child turns age 19.

Preventive Dental Care

This plan covers Preventive Dental Care services that help prevent oral disease from occurring. Such services are:

- Prophylaxis (scaling and polishing the teeth) at six (6) month intervals;
- Topical fluoride application twice in a 12-month period where the local water supply is not fluoridated;
- Sealants on unrestored permanent molar teeth; and
- Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

Routine Dental Care

This plan covers Routine Dental Care services provided in a dentist's office, such as:

- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
- X-rays, full mouth x-rays or panoramic x-rays at 36-month intervals, bitewing x-rays at six (6) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation; and
- Amalgam, composite restorations and stainless steel crowns.

Endodontics

This plan covers routine endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

Periodontics

This plan covers non-surgical periodontic services. We will periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects. This plan will also cover periodontic services in anticipation of, or leading to orthodontics that are otherwise covered under this Policy.

Prosthodontics

This plan covers the following prosthodontic services:

- Removable complete or partial dentures, including six (6) months follow-up care;
- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate;
- Interim prosthesis for enrolled children up to 16 years of age; and
- Single crowns, one (1) per tooth every 60 months and crown related services.

Implants or implant related services are not covered.

Fixed bridges are not covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

Oral Surgery

This plan covers non-routine oral surgery, such as:

- Partial and complete bony extractions;
- Tooth transplantation;
- Surgical access of an unerupted tooth;
- Mobilization of erupted or malpositioned tooth to aid eruption; and
- Placement of device to facilitate eruption of an impacted tooth.

The plan also covers oral surgery in anticipation of, or leading to orthodontics that are otherwise covered by this Policy.

Orthodontics

This plan covers orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as:

- Cleft palate and cleft lip;
- Maxillary/mandibular micrognathia (underdeveloped upper or lower jaw);
- Extreme mandibular prognathism;
- Severe asymmetry (craniofacial anomalies);
- Ankylosis of the temporomandibular joint; and
- Other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

Orthodontic treatment is covered only when Medically Necessary as evidenced by a handicapping malocclusion and when a prior authorization is obtained. Teeth must be 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.

The number and frequency of each of these services are limited. Refer to the Pediatric Dental – Limitations in Section 8 of this Policy.

The number and frequency of each of these services are limited. Refer to the Pediatric Dental – Limitations and Pediatric Dental – Exclusions in Section 8 of this Policy for specific covered services and excluded services.

Pediatric Vision Services

Pediatric Vision Services are available for Enrolled Children through the end of the month in which they turn 19 years of age.

The Enrolled Child may receive one routine eye exam per calendar year to determine the need for vision correction, including dilation if professionally indicated.

In addition to the routine eye exam, the Enrolled Child may receive one pair of eyeglasses, including standard frames and standard lenses, or contact lenses, per calendar year. Eyeglasses and contact lenses are limited to the least expensive professionally adequate materials. Contact lenses are limited to a one-year supply per calendar year.

Lenses include:

- single vision, bifocal, trifocal and lenticular;
- choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses; and

- scratch resistant coating.

Other optional lenses and treatments include:

- Ultraviolet Protective Coating
- Polycarbonate Lenses
- Blended Segment Lenses
- Standard Progressives
- Premium Progressives
- Photochromic Glass Lenses
- Plastic Photosensitive Lenses
- Polarized Lenses
- Standard Anti-Reflective Coating
- Ultra Anti-Reflective Coating
- Hi-Index Lenses

Medically Necessary Contact Lenses

Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism. Medically Necessary contact lenses are dispensed in lieu of other eyewear. Participating Providers will obtain the necessary Pre-Authorization for these services. We will pay for charges up to \$600 for Medically Necessary contact lenses. Charges that exceed the \$600 limit will be owed by You.

Low Vision

Services for low vision include:

- one (1) comprehensive low vision evaluation every five (5) years;
- low vision aids;
- Up to four (4) follow-up care visits in any five (5) year period.

Pre-authorization is required for low vision services and materials.

Pharmaceutical Products – Outpatient

This Plan covers 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

This Plan covers physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis. Care may be received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or by a house call by a Physician.

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

Physician's Services for Sickness and Injury

Coverage by the Plan includes services provided by a Physician, including a Specialist, for the diagnosis and treatment of a Sickness or Injury. Coverage includes Medically Necessary allergy testing, antigen administration and desensitization treatment.

Care may be provided at a Physician's office, in a freestanding clinic, in a Hospital, at the patient's

home, or provided as Telemedicine.

Coverage includes medical education services 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.

A description of covered services for Preventive Care when provided in a Physician's office are described under *Preventive Care Services*.

Clinic Fees

A Clinic Fee may be billed by a Provider when Physician's Office Services are received at an Outpatient Clinic that is owned by a hospital. Your Deductible and Coinsurance will apply to Clinic Fees.

Note: *If a diagnostic test or blood draw is performed during a Physician's Office Visit, the Physician's office may send the test or blood sample to a lab or other facility. If that occurs, the Plan's Lab, X-ray and Diagnostics provision of the Policy will apply.*

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.

Timely Post-Delivery Care

If the mother and attending Provider agree to discharge a mother and her newborn child from the inpatient setting before the expiration of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, We shall provide coverage for timely postdelivery care in a manner that meets the health care needs of the mother and her newborn child and that provides for the appropriate monitoring of the conditions of the mother and child and that occurs not later than the 72-hour period immediately following discharge. Care shall be provided to a mother and her newborn child by a registered nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health in:

- The home, a provider's office, a hospital, a birthing center, an intermediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or
- Another setting determined appropriate under federal regulations promulgated under Title VI of Public Law 104-204.

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)

Prescription Drugs

We use a Pharmacy Services Vendor to help manage the Prescription Drug benefit. Your cost and coverage of Prescription Drug Products from this benefit is impacted by the following factors:

- Eligibility at the time of service;
- The pharmacy filling Your prescription;
- The status of the medication on Our Formulary, its brand or generics status, its status as a Specialty Pharmacy medication; and
- Annual Deductibles, Copayments, Coinsurances, Days' Supply Limits, and other Quantity or Supply Limits.

Identification Card required for Prescription Services

You must show Your ID Card at the time You obtain Your Prescription Medications. The information on Your ID Card helps the pharmacy filling Your prescriptions verify that You are eligible, and determine the coverage and cost of Prescription Medications according to this benefit.

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

Pharmacy Network

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

Specialty Pharmacy

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

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

Please call Customer Service at (800) 237-2767 to find out which providers are in the Specialty Pharmacy Network program.

Mail order medications / Network Benefits

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

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

Formulary List

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

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

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

Quantity Limit or Supply Limits

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

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

Refer to the Formulary at www.brighthealthplan.com to find out which medications have a Quantity Limit restriction.

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.

Refer to the Formulary at www.brighthealthplan.com to find out which medications require Prior Authorization.

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 called "Step Therapy". 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. You received a copy of the appeals process with your Policy. You will also receive the 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 medication restrictions or limits. If We agree that the exception is Medically Necessary and the exception is approved, the medication will be covered at either:

- the tier for the drug listed within the formulary document for formulary drugs; or at the non-preferred brand tier for non-formulary drugs.

Examples of exceptions are:

- the medication that is normally covered has caused a harmful reaction to You;
- there is a reason to believe the medication that is normally covered would cause a harmful reaction; or
- the medication prescribed by Your qualified health care provider is more effective for You than the medication that is normally covered.

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

For 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) Drugs and Biologics Compendia; (2) The ThomsonMicromedex DrugDex, (3) The Elsevier Gold Standard's Clinical Pharmacology; or (4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services. 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.

Drug Tiers

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

Your Prescription Drug benefit includes coverage for the following drug tiers:

- Tier 1: Preventive Medications
- Tier 2: Generic Medications
- Tier 3: Preferred Brand Medications
- Tier 4: Non-Preferred Brand Medications
- Tier 5: Specialty Medications

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 the State of North Carolina recognizes such products as requiring a prescription or mandates coverage as such.
- Insulin is covered as a prescription product, along with:
 - cartridges including cartridges for the legally blind;
 - Medically Necessary injection aids;
 - syringes and monitors for the visually impaired;
 - lancets including automatic lancing devices
 - Glucose test strips;
 - Visual reading test strips;
 - Urine testing strips;
 - Glucagon;
 - Standard blood glucose monitors and Medically Necessary blood glucose monitors for the legally blind; and
 - Prescription Medications for controlling blood sugar (oral medications).
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins when a prescription is required for dispensing, to prevent or treat a specific medical condition.
- Compounded medications are covered when dispensed by a network pharmacy, and contain at least one prescription product for treatment of a covered condition, which has no commercially available prescription alternative. The Plan will cover the formulary prescription contents of the compounded medication. Any over the counter medications or ingredients included in the compound are not covered.
- Phenylketonuria (PKU) formulas and special food products are covered, and subject to the same deductibles, co-pays, and network providers as other prescription products, when used to treat PKU.
- Specialty Pharmaceutical medications, as defined by the plan when dispensed by our Specialty Pharmacy Network Supplier.
- Contraceptives medications, devices, and various other products are covered for use as birth control.

- Immunizations administered at a Network Pharmacy.
- Medications prescribed to treat emergency medical conditions while traveling outside the United States.

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

Prescription Drug Refill Limitations

For non-controlled substances, You cannot refill a prescription until 80% of the days supply has been used, except under certain circumstances such as during a government-declared state of emergency or disaster in the county in which you reside. In the case of a government-declared state of emergency, the prescription medication must be requested within 29 days after the Commissioner issues a Bulletin Advisory notifying all insurance carriers of the state of emergency, unless extended by an order issued by the Commissioner. This authorization of extra prescriptions during this state of emergency in the State of North Carolina is valid for prescription medication requests made within 29 days of issuance of this bulletin, unless extended by an order issued by the Commissioner.

For controlled substances, You cannot refill a prescription until 90% of the days supply has been used, except under certain circumstances such as a government-declared state of emergency or disaster in the county in which you reside. In the case of a government-declared state of emergency, the prescription medication must be requested within 29 days after the Commissioner issues a Bulletin Advisory notifying all insurance carriers of the state of emergency, unless extended by an order issued by the Commissioner. This authorization of extra prescriptions during this state of emergency in the State of North Carolina is valid for prescription medication requests made within 29 days of issuance of this bulletin, unless extended by an order issued by the Commissioner.

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.

You cannot refill a prescription until 70% of the days supply has been used, except under certain circumstances such as a government-declared state of emergency or disaster in the county in which you reside. In the case of a government-declared state of emergency, the prescription medication must be requested within 29 days after the Commissioner issues a Bulletin Advisory notifying all insurance carriers of the state of emergency, unless extended by an order issued by the Commissioner. This authorization of extra prescriptions during this state of emergency in the State of North Carolina is valid for prescription medication requests made within 29 days of issuance of this bulletin, unless extended by an order issued by the Commissioner.

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/>.

Synchronization of Prescription Refills

When agreed upon by You, Your Physician and Your Pharmacist that synchronization of multiple prescriptions for the treatment of a chronic illness is in Your best interest, We will provide coverage for synchronization of Your medication provided all of the following apply:

- The medications are covered by the clinical coverage policy.
- The medications are used for treatment and management of chronic conditions, and the medications are subject to refills.
- The medications are not a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.
- The medications meet all pre-authorization criteria specific to the medications at the time of the synchronization request.
- The medications are of a formulation that can be effectively split over required short-fill periods to achieve synchronization.
- The medications do not have quantity limits or dose optimization criteria or requirements that would be violated in fulfilling synchronization.

Government-Declared State of Emergency

If there is a government-declared state of emergency or disaster in the county in which you reside, you must request a refill within 29 days after the Commissioner issues a Bulletin Advisory notifying all insurance carriers of the state of emergency, unless extended by an order issued by the Commissioner. This authorization of extra prescriptions during this state of emergency in the State of North Carolina is valid for prescription medication requests made within 29 days of issuance of this bulletin, unless extended by an order issued by the Commissioner. A refill of a prescription with quantity limitations may take into account the proportionate dosage use prior to the disaster.

What You Must Pay

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

Preventive and Wellness Services

Covered Health Services under this section include federal and state mandated preventive health care services.

Federally-Mandated Preventive Health Care Services

Federally mandated preventive health care includes services in accordance with the A or B recommendations of the U.S. Preventive Services Task Force; evidence-informed preventive care and screenings provided for in Health Resources & Services Administration guidelines for infants,

children, adolescents, and women; and immunizations that have a recommendation from the Advisory Committee on Immunization Practices.

When the following services are received from a Network Provider, they are covered at 100% 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 at 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:
 - A baseline mammogram for a woman from age 35-39;
 - A mammogram every year for a woman 40 years of age and over.
- 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 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). Such services include:
 - 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
- 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 coverage for all persons over age 50 and continuing until the age of 75 years.
- 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 depression in the general adult population including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
- Diabetes screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. 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.
- Hearing screening during annual wellness check for adults and children;
- Hemoglobinopathies screening for sickle cell disease in newborns.
- Hepatitis B screening in pregnant women at their first 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 provide or refer women who screen positive to ongoing support services;
- 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;
- Nutritional Counseling for maintaining or achieving a healthy weight;
- Obesity Screening and Counseling for adults and children: 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.
- Surveillance tests for ovarian cancer such as CA-125 serum tumor marker testing, Transvaginal ultrasound, or pelvic examination.
- Syphilis screening for pregnant women and 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 USPSTF 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.
- Vision Screening during annual wellness check for adults and children.
- 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-baby visits and care up to the age of 47 months, including immunizations.
- Any other preventive services included in the A or B recommendations of the task force for the particular preventive health care service, or services recommended by the Health Resources & Services Administration or Advisory Committee on Immunization Practices, 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 calendar year, the service will not be considered Preventive and the Plan's Lab, X-Ray and Diagnostics benefits will apply. Services will be subject to the Plan's Annual Deductible, Copayment, or Coinsurance.*

State Mandated Preventive Health Care Services

- Bone Mass Measurement Services - To qualify for coverage of this benefit, one or more of the following criteria must be satisfied:
 - An individual is estrogen-deficient and at clinical risk of osteoporosis or low bone mass;
 - An individual has radiographic osteopenia anywhere in the skeleton;
 - An individual is receiving long-term glucocorticoid (steroid) therapy;
 - An individual has primary hyperparathyroidism;
 - An individual is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;
 - An individual has a history of low-trauma fractures; or
 - An individual has other conditions or on medical therapies known to cause osteoporosis or low bone mass.
- Colorectal Screening - Colorectal cancer examinations and laboratory tests for cancer are covered for any symptomatic or asymptomatic **member** who is at least 50 years of age, or is less than 50 years of age and at high risk for colorectal cancer.

- Gynecological Exam and Cervical Cancer Screening - includes the examination and laboratory tests for early detection and screening of cervical cancer, and a Physician's interpretation of the lab results. Coverage for cervical cancer screening includes Pap smear screening, liquid-based cytology, and human papillomavirus detection, and will follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.
- Newborn Hearing Screening - Coverage is provided for newborn hearing screening ordered by a physician to determine the presence of permanent hearing loss.
- Ovarian Cancer Screening - For female **members** ages 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered. A person is considered "at risk" if they:
 - have a family history with at least one first-degree relative with ovarian cancer; and a second relative, either first-degree or second-degree with breast, ovarian, or nonpolyposis colorectal cancer; or
 - tested positive for a hereditary ovarian cancer syndrome.
- Prostate Screening - One prostate specific antigen (PSA) test or an equivalent serological test will be covered per Covered male per calendar year. More PSA tests will be covered if recommended by a Physician.
- Screening Mammograms - Coverage includes one baseline mammogram for any female member between the ages of 35 and 39. Beginning at age 40, one screening mammogram will be covered per female member per calendar year, along with a Physician's interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a Physician when female members are considered at risk for breast cancer. Female members are considered at risk if they:
 - have a personal history of breast cancer
 - have a personal history of biopsy-proven benign breast disease
 - have a mother, sister, or daughter who has or has had breast cancer, or
 - have not given birth before the age of 30.

Private Duty Nursing

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

Prosthetic Devices

Covered Health Services under this section include external prosthetic devices that replace a limb or a body part, limited to:

- Prosthetics will be covered in accordance with Medicare guidelines and criteria.
- Bionic, myoelectric, microprocessor-controlled, and computerized Prosthetics are covered in accordance with Medicare guidelines and criteria.
- Artificial face, eyes, ears, noses, legs. Arms and terminal devices such as a hand or hook.
- 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.

Implanted Medical Devices

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;
- Treatment of physical complications of the mastectomy, including lymphedema;
- At least two postoperative prosthesis subject to the terms and conditions of this policy.

The decision to discharge the patient following a mastectomy is to be made by the treating Physician and the member. The length of post mastectomy hospital stay is based on the unique characteristics, health and medical history of the patient.

Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating Physician.

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.

Rehabilitative and Habilitative Services – Outpatient Therapy

Covered Health Services under this section include short-term outpatient Rehabilitative Services, limited to 30 visits per calendar year combined between the following services:

- Physical therapy
- Occupational therapy
- Chiropractic Manipulations

The Plan covers the therapeutic application of manual Chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain, and improve function.

The following are specifically excluded from chiropractic care and osteopathic services:

- Services of a chiropractor or osteopath which are not within his or her scope of practice, as defined by state law.
- Charges for care not provided in an office setting.
- Manipulation under anesthesia.
- Maintenance or preventive treatment consisting of routine, long term or Non-Medically Appropriate care provided to prevent reoccurrences or to maintain the patient's current status.
- Vitamin or supplement therapy.
- Infusion therapy or chelation therapy.

Speech therapy is also a Covered Health Service and is limited to 30 visits per calendar year. Speech therapy is not covered when it is:

- Used to improve speech skills that have not fully developed;
- Considered custodial or educational;
- Intended to maintain speech communication; or
- Not restorative in nature.

Cardiac and Pulmonary Rehabilitation are also Covered Health Services under this section.

Outpatient Therapy 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.

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*.

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.

Sexual Dysfunction

Coverage by the Plan includes certain services related to the diagnosis, treatment and corrections of any underlying causes of sexual dysfunction.

Skilled Nursing Facility

Coverage by the Plan includes charges incurred while confined in a Skilled Nursing Facility. Coverage is available for:

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

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

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

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

Coverage is limited to sixty (60) days per calendar year.

Sleep Studies

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

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

Surgery – Outpatient

Covered Health Services under this section include surgery and related services for a Sickness, Injury, or condition that are received on an outpatient basis at a Hospital or Alternate Facility. For the purposes of this benefit, congenital heart disease is considered a Sickness.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, and hysteroscopy.

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

Temporomandibular Joint Disorder (TMJ)

Covered Health Services under this section include Medically Necessary services for the treatment of TMJ or any bone or joint of the face or head, which a result of an accident, trauma, a congenital or developmental defect, illness or a pathology.

Covered Health Services include diagnosis and treatment of TMJ that is recognized by the medical

or dental profession as effective and appropriate for TMJ including splinting, intraoral prosthetic appliances used to reposition the bones, or any other Medically Necessary procedures involving any bone or joint of the jaw or face.

Coverage is not provided for orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, or root canals, unless otherwise stated in the Pediatric Dental section of this policy.

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/stem cell, heart, heart/lung, lung, kidney, kidney/pancreas, kidney/liver, liver, liver/small bowel, pancreas, small bowel, and cornea.

Transplant Benefit expenses include services related to donor search and acceptability testing of potential live donors. 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.

No benefits are available where the Member is an organ donor for a recipient other than a Member enrolled on the same family 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.

Organ transplant travel benefits are not available for cornea transplants.

Benefits for transportation, lodging and food are available only for the recipient of a pre-approved organ/tissue transplant from a transplant facility. The term recipient is defined to include a Covered Person receiving authorized transplant related services during any of the following:

- Evaluation;
- Candidacy;
- Transplant event; or
- Post-transplant care.

Travel expenses for the recipient of the transplant will include charges for:

- Transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
- Transportation to and from the transplant site in a personal vehicle will be reimbursed at the federal CONUS rate when the transplant site is more than 60 miles one way from the Member's home.
- Lodging while at, or traveling to and from the transplant site;
- Food while at, or traveling to and from the transplant site.

Personal vehicle travel expenses are reimbursable if We direct You for treatment at a transplant site that is more than 60 miles from Your home.

All claims filed for travel expenses must include detailed receipts, except for mileage. Transportation mileage will be calculated by Us based on the home address of the transplant recipient and the transplant site.

In addition to the recipient being covered for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany the

recipient. The term companion includes Your spouse, a member of Your family, Your legal guardian, or any person not related to You, but actively involved as your caregiver.

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.

Travel Expenses require pre-authorization from the plan.

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 the Covered Health Service categories described in *Benefits/Coverages (What is Covered)* section of this Policy, those limits are stated 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 category. When this occurs, the limits are stated in the *Schedule of Benefits (Who Pays What)* section of this Policy under the heading *Plan Limitations*. Please review all limits carefully, as We will not pay Benefits for 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 Health Care Treatments

Alternative health care treatments are not covered by the Plan. Some examples of alternative treatments or therapies are:

- Acupuncture;
- Acupressure;
- Aromatherapy;
- Hydrotherapy;
- Hypnotism;
- Massage therapy;
- Naturopathy;
- Rolfing; and
- Alternative treatments as defined by the National Center for Complementary and Alternative Medicine (NCCAM). Examples of these are art, music, dance and horseback therapy.

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, except as stated in the What is Covered section of this Policy.

Dental Care

Dental care is not covered, except as defined under Section 7, Pediatric Dental Care.

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; and
- The direct treatment of cancer or cleft lip or cleft palate.

Dental care that is required to treat the effects of a medical condition is not covered. 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 not covered, except as defined under Section 7, Pediatric Dental Care.

Preventive care, diagnosis and treatment of or related to the teeth, jawbone and gums are not covered, except as defined under Section 7, Pediatric Dental Care. Examples include:

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

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

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

Treatment of congenitally missing, mal-positioned, or supernumerary teeth, even if part of a Congenital Anomaly are not covered.

Dentures, Bridges, Crowns and other dental prostheses are not covered.

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 6 months from the date of the accident or injury. Dental services received more than 6 months after the accident or injury are not covered.

Devices, Appliances

Health care services that are not covered by the Plan, even if prescribed by a Physician are:

- Devices used specifically as safety items or to affect sports performance;
- Orthotic appliances that straighten or re-shape a body part except for Positional Plagiocephaly, such as foot orthotics (except for diabetic shoes), cranial banding and some types of braces, including over-the-counter orthotic braces;
- Enuresis alarms;
- Blood Pressure cuff/monitors;
- Home coagulation testing equipment;
- Non-Wearable external defibrillators;
- Trusses;
- Ultrasonic nebulizers;
- Devices and computers used to assist in communication and speech, except for speech aid prosthetics and tracheo-esophageal voice prosthetics;
- Oral appliances to treat sleep apnea or snoring; and
- Corrective shoes and orthotic devices for podiatric use and arch supports, except those used for diabetic shoes.

Directed Blood Donations

Directed Blood Donations are not covered by this Plan.

Employer or Governmental Responsibility

A financial responsibility for services that an employer or a government agency is required by law to pay, is not covered by this Plan.

Experimental, Investigational, or Unproven Services

Experimental services, Investigational services, Unproven services and any related services are not covered by the Plan. If the regimen is the only available treatment for a condition, it will not be covered.

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 by the FDA.

This exclusion does not apply to Covered Health Services that may be provided during a clinical trial.

Foot Care

Health care services excluded by the Plan are:

- 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 to maintain skin tone
- Shoes
- Treatment of flat feet

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

Genetic Testing

Most Genetic Testing is not covered. Genetic testing is only covered by the Plan if it is Medically Necessary to identify a genetic disease that may be inherited. Please refer to Section 7, Genetic Testing, and Preventive and Wellness Services, to read about Genetic Testing that is covered by the Plan.

Infertility/Reproduction

The following Infertility and Reproductive services are not covered by the Plan:

- Services to reverse voluntary, surgically induced infertility;
- Donor semen, donor eggs and services related to their procurement and storage;
- GIFT procedures;
- Foams and condoms;
- 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, embryo or ovum transplants, gamete intra fallopian transfers and zygote intra fallopian transfers. 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; and
- Genetic testing of embryos pre or post implantation.

Medical Supplies and Equipment

Health care supplies and equipment not covered by the Plan include medical supplies and disposable supplies, unless provided through Diabetes Services, Home Health Care or covered as Ostomy Supplies. Examples of supplies are:

- Elastic stockings;
- Ace bandages;
- Antiseptics;
- Gauze and dressings;
- Tubing and masks;
- Deodorants;
- Filters;
- Lubricants;
- Tape;
- Appliance cleaners;
- Adhesive; and
- Adhesive remover.

Neurobiological Disorders

Health care services excluded under this provision include:

- 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.

This exclusion does not apply to treatments related to Autism Spectrum Disorder or Habilitative Services.

Nutrition

Health care services not covered by the Plan are:

- 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 are supplements, electrolytes, and foods of any kind.
- Individual and group nutritional counseling. Services are covered when medical nutritional education services are provided by an appropriately licensed or registered health care professional; and when nutritional education is required for a disease in which patient self-management is an important component of treatment; and there is a knowledge deficit regarding the disease which requires the intervention of a trained health professional. Please refer to the Nutritional Evaluation, Counseling, and Self-Management Training in Section 7 - Benefits/Coverage (What is Covered).

Other Services

Other health care services not covered by the Plan are:

- 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; and
- 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.

- 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.
 - 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.
- The annual benefit maximum for non-orthodontic services is \$1,200.
- 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.
- The lifetime benefit maximum for Orthodontic services is \$1,500.

Pediatric Dental Care - Exclusions

The Pediatric Dental Care plan will not pay Benefits for:

- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Services and treatment which are experimental or investigational;
- Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
- Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;
- Services and treatment performed prior to your effective date of coverage;
- Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
- Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.
- Services and treatment resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);

- Services or treatment provided as a result of intentionally self-inflicted injury or illness;
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailling copies of your records, charts or x-rays;
- State or territorial taxes on dental services performed;
- Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;
- Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- Those for which the member would have no obligation to pay in the absence of this or any similar coverage;
- Those which are for specialized procedures and techniques;
- Those performed by a dentist who is compensated by a facility for similar covered services performed for members;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Gold foil restorations;
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
- Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- Charges by the provider for completing dental forms;
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Orthodontic care for dependent children age 19 and over;
- Orthodontic care for members and spouses;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliance;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
- Fabrication of athletic mouth guard;
- Internal bleaching;
- Nitrous oxide;
- Oral sedation;
- Topical medicament center
- Bone grafts when done in connection with extractions, apicoectomies or non-covered/non-eligible implants;
- When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by Us.
- When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by Us.

- All out of network services listed in Section 5 are subject to the usual and customary maximum allowable fee charges as defined by Us. The member is responsible for all remaining charges that exceed the allowable maximum.
- 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;
- Maxillofacial prosthetics.
- 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.
- 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.
- Treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- 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 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.

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:

- 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.
- Toupees, hair transplants or hair weaving for male pattern baldness.

Physician Assisted Suicide

Services provided by a Physician or other medical professional to assist a member in ending his or her life are not covered by this plan.

Prescription Drugs Exclusions

The following Prescription drugs and services are excluded under the Plan:

- Prescription Drug Products obtained through a Non-Network Pharmacy.
- Non-Prescription Medications, unless specifically covered elsewhere in this document, or as mandated by Law.
- Medications for conditions that are excluded from coverage.
- Medications that are 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, except under certain circumstances during a state of emergency or disaster.
- Medications prescribed solely for cosmetic purposes.
- Human Growth Hormone prescribed to adults for any reason.
- Medications available as bulk powders 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 Medical Condition treatment.
- Prescription Drug Products furnished by local, state, or federal governments. 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 of Benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Durable Medical Equipment.
- Prescribed and non-prescribed outpatient supplies, other than diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins except as described under the Preventive and Wellness Services of the Benefits/Coverage (What is Covered) section of this Policy.
- Medication prescribed for the treatment of hair loss.

- Off-label use of medications unless required by Law, then allowed in accordance with Law.
- Biological sera, blood, blood products or plasma.
- Oxygen, Medical Devices or Equipment, unless specifically listed as covered.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms that We determine do not meet the definition of a Covered Health Service.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except for Medical Foods prescribed for the treatment of Inherited Enzymatic Disorders.
- Allergy serum.
- Topical medications for the treatment of onychomycosis of the toenails.
- 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 for any reason, including medical marijuana.

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. Additional quantity limitations may apply to specific medications.
- If a member requests a brand medication when there is a generic equivalent, the brand medication will be covered up to the charge that would apply to the generic medication, minus any required copayment. If a physician requests that a brand medication be dispensed as written, the medication will be paid at the non-formulary (Tier 4) benefit.
- The member copayment for a medication will not exceed the cost of the medication.
- If a member copayment is required, you must pay one member copayment for each 30-day supply, or portion thereof, except for Mail Order Medications.

Procedures and Treatments

The following Procedures and Treatments are excluded:

- 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 that is:
 - Used to improve speech skills that have not fully developed;
 - Considered custodial or educational;
 - Intended to maintain speech communication; or
 - Is not restorative in nature.
- 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

The following Provider Services are excluded from coverage under the Plan:

- Services performed by an unlicensed provider who is a family member by birth or marriage. This includes any service the unlicensed provider may perform on himself or herself.

- Services performed by an unlicensed 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. Services must be received by a Network Provider.

Services Received Outside of Your Policy Coverage Period

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

Services Rendered by a Non-Participating Provider

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

Exceptions to this exclusion are:

Services for Emergency Medical Conditions;

You are treated by a Non-Network Provider while you are receiving care at a Network facility; or

We authorize Medically Necessary care to a Non-Network Provider because the care is not available from a Network Provider.

Services that are not Medically Necessary

Services that are not Medically Necessary are not covered by the Plan.

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

Travel services not covered by the Plan are:

- Non-Network health care services provided in a foreign country, except as required in the case of an Emergency Medical Condition.
- Travel expenses, even though prescribed by a Physician, except as described in the *Travel* provision of the *Benefits/Coverage (What is Covered)* section of this Policy.

Types of Care

Health care services excluded under this provision include:

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

Vision Services

Vision services not covered by the Plan are:

- The purchase cost and fitting charge for eyeglasses; frames; or contact lenses; except as covered for children under age 19.
- 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 to help you see better without glasses or other vision correction, such as 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 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 during service in the armed forces of any country.
- Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
- Inpatient stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- Long-term (more than 30 days) storage of products such as cryopreservation of tissue, blood, and blood products.
- Medical services and procedures that are not legal.
- Missed and canceled appointments.
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under this Policy when:
 - Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage, or adoption.
 - 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.

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 Covered)* 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.*

You will be responsible for all charges if You elect to receive care from a Non-Network Provider without Pre-authorization from Us. This does not apply for Non-Network emergency care, services

from a Non-Network Provider in a Participating facility, or services for which we have issued a network exception.

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. Copayments are normally required at the time of service. Deductible and Coinsurance amounts may be due later when You receive a bill from Your provider. If you receive a bill from Your provider, We encourage you check Your Explanation of Benefits, call Customer Service or login to Your Member Portal to make sure that the charges You are being billed for are consistent with what We have paid.

Assignment of Benefits

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

When you see an Out-of-Network Provider, they may require payment from You and You may have to submit the claim to Us. We may choose to pay You or to pay the out-of-network provider directly, if covered.

Required Claim Information

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

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

Notice of Claim or Proof of Loss

Written notice of claim or proof of loss must be furnished to Us within 365 days after the occurrence of any loss covered by the policy, or as soon thereafter as is reasonably possible. Electronic submission of the notice of claim or proof of loss is acceptable as submission on paper. Failure to furnish such notice of claim or proof of loss within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time. In no event, except in the absence of legal capacity of the claimant, shall proof be furnished later than one (1) year from the date of loss.

There is no paperwork for claims for services from Network Providers. You will need to show Your ID card and pay any required copayment; Your Network Provider will submit a claim to Us for reimbursement. Claims for care of an Emergency Medical Condition 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 Submissions and Correspondence Address:

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

Claim Forms

When a request for a claim form or the notice of a claim is provided to Us, We will provide the claimant or policyholder the claim forms required for filing. If the claimant does not receive these claim forms within 15 days after the Plan receives notice of claim or the request for a claim form, the claimant will be considered to meet the proof of loss requirement of this Policy. Foreign claims must be translated in U.S. currency prior to being submitted to the Plan for payment.

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

Payment of Claims Upon Death

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

Time for Payment of Claims

When all required information is submitted, We will make an initial benefit determination and claims payment within 30 days of receipt of due written Proof of Loss.

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 90 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. Absent fraud, all claims will be paid, denied or settled within 90 days.

If We deny the claim, We shall provide notice to include all of the specific good faith reason or reasons for the denial, including, without limitation, coordination of benefits, lack of eligibility, or lack of coverage for the services provided. If the claim is contested or cannot be paid because the Proof of Loss is inadequate or incomplete, or not paid pending receipt of requested coordination of benefits information, the notice shall contain the specific good faith reason or reasons why the claim has not been paid and an itemization or description of all of the information needed by the insurer to complete the processing of the claim. If all or part of the claim is contested or cannot be paid because of the application of a specific utilization management or Medical Necessity standard is not satisfied, the notice shall contain the specific clinical rationale for that decision or shall refer to specific provisions in Our policies that are made readily available and which provide the specific clinical rationale for Our decision; however, if a notice of non-certification has already been provided under G.S. 58-50-61(h), then the specific clinical rationale for the decision is not required under this subsection. If the claim is contested or cannot be paid because of nonpayment of premiums, the notice shall contain a statement advising the claimant of the nonpayment of premiums. If a claim is not paid pending receipt of requested coordination of benefits information, the notice shall so specify. If a claim is denied or contested in part, We shall pay the undisputed portion of the claim within 30 calendar days after receipt of the claim and send the notice of the denial or contested status within 30 days after receipt of the claim. If a claim is contested or cannot be paid because the claim was not submitted on the required form, the notice shall contain the required form, if the form is other than a UB or HCFA form, and instructions to complete that form. Upon receipt of additional information requested in its notice to the claimant, We shall continue processing the claim and pay or deny the claim within 30 days after receiving the additional information.

Claim payments that are not made within the specified timeframes shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid. If additional information was requested by Us, interest on claim payments shall begin to accrue on the 31st day after we have received the additional information.

If a claim for which the claimant is a Provider or Facility has not been paid or denied within 60 days after receipt of the initial claim, We shall send a claim status report to You. Provided, however, that

the claims status report is not required during the time We are awaiting information requested. The report shall indicate that the claim is under review and that We are communicating with the Provider or Facility to resolve the matter. While a claim remains unresolved, We shall send a claim status report to the insured with a copy to the Provider 30 days after the previous report was sent

Recovery of Overpayments

We may recover overpayments made to a Provider or Facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of North Carolina law. Not less than 30 calendar days before We seeks overpayment recovery or offsets future payments, We shall give written notice to the Provider or Facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments shall be made within the two years after the date of the original claim payment unless the insurer has reasonable belief of fraud or other intentional misconduct by the Provider or Facility, or its agents, or the claim involves a Provider or Facility receiving payment for the same service from a government payor. The Provider or Facility may recover underpayments or non-payments by the insurer by making demands for refunds. Any such recoveries by the Provider or Facility of underpayments or non-payment by the insurer may include applicable interest. The recovery of underpayments or non-payments shall be made within the two years after the date of the original claim adjudication, unless the claim involves a Provider or Facility receiving payment for the same service from a government payor.

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. Except in the absence of legal capacity, 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

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, and Annual Deductible charges
- 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 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.

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 activities, wellness programs or certain disease management programs. Such activities may include:

- Completing a brief health survey;
- Creating an account in our Member Hub; or
- Selecting a Primary Care Provider.

These activities require additional action from You. If, due to a disability or health condition, you are unable to complete these activities, We will provide reasonable accommodations or offer you alternate opportunities to earn incentives. The decision about whether or not to participate is Yours alone.

We recommend that You discuss participating in applicable disease management programs with Your Physician. Contact Us if You have any questions.

In addition, We may arrange for third party service providers to offer discounted goods and services to Covered Persons under the Plan. While We have arranged these goods, the third-party service providers are liable to the Covered Person for the provision of such goods and/or services. We are not responsible for the provision of such goods and/or services, nor for the failure of the provision of the goods and/or services. Further, We are not liable to the Covered Person for the negligent provision of such goods and/or services by third-party service providers.

Rebates and Other Payments

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

Interpretation of Benefits

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

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

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

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*. You can obtain Our Notice of Privacy Practices in the Member Hub, on our website at www.brighthealthplan.com, in Your welcome kit that included Your Identification Card, or by contacting Bright Health Plan Customer Service at (855) 521-9349.

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. Records may be necessary to complete appropriate medical review or quality assessment. We may also be required to release medical records by law or regulation. We may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Our related entities may use and transfer the information, as well. Please refer to Our Notice of Privacy Practices for details on how the information may be used.

For 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 may charge You reasonable fees to cover costs for completing the forms or providing the records.

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

Extension of Benefits

If You are hospitalized on the end date of your Policy with Us and Your Policy is not being terminated for non-payment, We will extend coverage beyond your termination date until You are discharged from the hospital. Coverage will end the day 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.

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.

Medicaid Reimbursement

The amount provided or payable under this Policy will not be changed or limited for reason of a Covered Person being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this Policy to the state if:

A member is eligible for coverage under his or her state's Medicaid program; and

We receive proper proof of loss and notice that payment has been made for covered service expenses under that program.

Our payment to the state will be limited to the amount payable under this Policy for the Covered Service expenses for which reimbursement is due. Payment under this provision will be made in good faith and will satisfy Our responsibility to the extent of that payment.

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 North Carolina Industrial Commission, if necessary.

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

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

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

- If You qualify under North Carolina 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.

Limitation of Action

You cannot take any legal action against Us for any expense or bill until 60 days after We receive written submission of claim.

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

Change of Beneficiary

Unless the insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to the insured 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.

Conformity with State Statutes

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

Fraudulent Insurance Acts Notice

It is against the law 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 for fraud 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 North Carolina Department of Insurance. 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. If we determine that an act of fraud was perpetrated, We may rescind the coverage under this Policy retroactively to the date in which the fraudulent act was committed. We may rescind coverage if You have committed fraud or an intentional misrepresentation of material fact in applying for coverage in or receiving or filing for Benefits. We will provide You with a thirty (30) day advanced written notice prior to rescinding Your coverage.

Time Limit on Certain Defenses

After the Policy has been in effect for two years, 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.

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.

Pre-Existing Conditions

This plan will not discriminate based on the health status, pre-existing conditions or genetic information of any applicants or renewing Enrollees.

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, including any change in coverage of Preventive and Wellness Services.

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 Eastern 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 North Carolina. To the extent that state law applies, the laws of the State of North Carolina 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 dis-enroll from programs/services offered by Us. If You refuse medical care, Your health care professional should tell You what might happen. We urge You to discuss Your concerns about care with Your primary care Physician or other participating health care professional. Your Physician or health care professional will give You advice, but You will have the final decision.
- Be heard. Our complaint-handling process is designed to: hear and act on Your complaint or concern about Us and/or the quality of care You receive from health care professionals and the various places You receive care in our network; provide a courteous, prompt response; and guide You through Our appeal process if You do not agree with Our decision.
- Make recommendations regarding Our policies that affect Your rights and responsibilities.

You Have the Responsibility to:

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

Section 12 - Termination/Nonrenewal/Continuation

General Information About When Coverage Ends

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

We will provide You with a thirty (30) day advanced written notice prior to terminating Your coverage.

Unless otherwise stated, the date of termination shall be the last day of the month for which premium has been received and accepted by Bright Health. Termination of the Subscriber's coverage shall also terminate coverage for the Subscribers enrolled Dependents.

- Loss of eligibility due to the Subscriber no longer living or working in the Service Area served by Bright Health;
- 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.
- You have ceased enrollment in a bona-fide association under which this Policy is issued, but only if coverage is terminated without regard to any health status related factor.
- We decide not to renew all of Our individual or child-only plans in the State of North Carolina. In this case, We will provide notice of the decision not to renew the plans to all affected individuals and to the State Insurance Commissioner. We will provide notice at least 180 days before Our non-renewal of the plans.
- We decide to discontinue a particular Plan. In this case we will provide ninety (90) days advance written notice to the Subscriber prior to termination of coverage.
- When the State Insurance Commissioner finds that the continuation of Your plan would not be in Your best interest or Your plan is obsolete or Your plan would impair Our ability to meet Our contractual obligations. In this case, We will provide notice of discontinuance at least 90 days prior to the date of discontinuance. We will provide You with the opportunity to purchase any other non-group plan offered by Us.
- We stop operations. We must pay for services for the rest of the time that premiums have already been paid.
- When enrollment was erroneous or inappropriate. If enrollment occurred in error or inappropriately, We reserve the right to rescind the policy.
- We receive a written notice from You instructing Us to cancel Your or Your Dependent's coverage. If any premium has been paid for the time period following the requested date of termination and no claims have been submitted to Us for dates of service after the requested date of termination, we will refund or credit that premium within 30 days of the request for termination. In the case of 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.
- 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 mental retardation or physical handicap and is chiefly dependent upon the policyholder for support, 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.
- Fraud, including improper use of Your ID card or intentional misrepresentation of material fact. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact may result in termination or rescission of this Policy. This Policy may also be terminated if You participate in or permit fraud or deception by any Provider, vendor, or any other person associated with this Policy. Termination of Coverage will be effective on the date we mail the written notice of termination to You. Rescissions will be as the coverage effective date, and it will be as if You were never covered under this Policy. We will provide You with thirty (30) days written notice prior to rescinding coverage.

Grace Period

When *You are* receiving a premium subsidy:

After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if advance premium tax credits are received.

We will continue to pay all appropriate claims for Covered Services rendered to a *Covered Person* during the first month of the grace period, and may pend claims for covered services rendered to in the second and third month of the grace period. We will notify HHS of the non-payment of premiums, the *Covered Person*, as well as Providers of the possibility of denied claims when the member is in the second and third month of the grace period. We will continue to collect advance premium tax credits on behalf of the *Covered Person* from the Department of the Treasury, and will return the advance premium tax credits on behalf of the *Covered Person* for the second and third month of the grace period if the *grace period is exhausted* as described above. A *Covered Person* is not eligible to re-enroll once terminated, unless a *there is* a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

When a member is not receiving a premium subsidy:

Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a one (1) month grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the policy will stay in force; however, claims may pend for covered services rendered to the *Covered Person* during the grace period. We will notify HHS, as necessary, of the non-payment of premiums, the *Covered Person*, as well as Providers of the possibility of denied claims when the member is in the grace period.

Premium Payments

Each premium payment is to be paid on or before its due date. The initial premium payment must be paid prior to the coverage effective date.

Premium Payments from Third-Party Payors

We require each policy holder to pay his or her applicable Premiums. The following are the ONLY acceptable third parties who may pay Premiums on your behalf:

- Ryan White HIV/AIDS Program under Title XXVI of the Public Health Services Act;
- Indian tribes, tribal organizations or urban Indian organizations;
- State and Federal government programs; or
- Family members.

Upon discovery that premiums were paid by a person or entity other than those listed above, We will reject the payment and inform the Subscriber that the payment was not accepted and that the Premium charges remain due.

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.

Certificate of Creditable Coverage

We will supply a Certificate of Creditable Coverage when Your or Your dependent's coverage under this policy ends or You exhaust continuation of coverage. Keep the Certificate of Creditable Coverage in a safe place. You may request a Certificate of Creditable Coverage while you are still covered under this Policy and up to 24 months following your termination. You may call the Customer Service to request the Certificate of Creditable 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. The Appeals and/or Grievance processes are voluntary, and may be requested by You or Your authorized representative. Below is a brief description of each of these processes.

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.

Adverse Determination

We consider the following situations to be an Adverse Determination:

- Denial of Services is when we deny a claim for health care services under this plan.
- Noncertification occurs when We or determine that services do not meet Our requirement for Medical Necessity, appropriateness of level of care or effectiveness.

If we issue a Denial or a Noncertification, we will send written notification of the Adverse Determination 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.

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.

First-Level Grievance Review

Your grievance request must be submitted to Us within 180 calendar days after You receive notice of the Adverse Determination You are appealing.

We do not allow You or Your authorized representative to attend the first-level grievance review.

Within three (3) business days after receiving the grievance, We will provide You with information about how to submit written material related to the grievance.

We will provide the You and if applicable, Your provider, a written decision within thirty (30) days after receiving the grievance.

Our grievance reviewers are not the same person or persons who initially handled the matter that is the subject of the grievance.

For grievances involving a clinical issue, at least one reviewer is a medical doctor with appropriate expertise to evaluate the matter.

When a decision is not in Your favor, We will provide a written decision that contains:

- The professional qualifications and licensure of the person or persons reviewing the grievance.
- A statement of the reviewer's understanding of the grievance.
- The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the Our position.
- A reference to the evidence or documentation used as the basis for the decision.
- Notice of the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.
- A statement, "You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available in your state is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

For grievances concerning quality of care delivered by Your provider, We will provide an acknowledgement to You within ten (10) business days of receipt. The acknowledgement will advise You that (1) We will refer the grievance to its Quality of Care Committee for review and resolution and (2) state law does not allow for a second-level review for grievances concerning quality of care.

Appeal of an Adverse Determination

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

Notice of Noncertification

If You receive a notice of non-certification, it will include all the reasons for the non-certification with the clinical rationale and instructions for submitting a voluntary appeal of the non-certification, instructions for requesting a written statement of the clinical review criteria used to make the decision, and the availability of assistance from Health Insurance Smart NC including the address and phone number.

Appeals of Noncertifications

We will accept appeals of non-certifications from Your or Your Provider including expedited reviews to address a situation where the timeframe for standard review would reasonably appear to seriously jeopardize Your life or health or Your ability to regain maximum function.

Each appeal of a non-certification is reviewed by a medical physician licensed to practice medicine in North Carolina who was not involved in the initial non-certification.

Standard (Non-Expedited) Appeals

We will notify You within three (3) business days of receiving a standard (non-expedited) appeal request. We will provide You with information about how to submit information regarding the appeal, including and the name, address and phone number of the appeal coordinator

We will provide You and Your Provider with written notification of the decision for a non-expedited appeal within thirty (30) days after receipt of the request for appeal. The written decision will contain:

- The professional qualifications and licensure of the person or persons reviewing the appeal.
- A statement of the reviewers' understanding of the reason for the appeal.
- The reviewers' decision in clear terms and the medical rationale in sufficient detail for You to respond further.
- A reference to the evidence or documentation that is the basis for the decision.
- For non-certification or other clinical matters, a written statement of the clinical rationale, including the clinical review criteria that was used to make the appeal determination.
- A statement that the decision is Our final determination. For non-certification or other clinical matters where We uphold Our initial decision, a statement advising You of Your right to request an External Review, including the procedure for submitting requests to the Commissioner of Insurance.
- Notice of the availability of assistance from Health Insurance Smart NC including the address and telephone number.

Expedited Appeals

We will accept requests for an expedited appeal from Your or Your Provider when a non-expedited appeal would reasonably appear to seriously jeopardize Your life or health or ability to regain maximum function. Additionally, Your provider is permitted to determine the appeal to be urgent.

We may require documentation or medical justification for the expedited appeal.

In consultation with a medical physician licensed to practice medicine in North Carolina, We will conduct an expedited review and communicate the decision in writing to You and Your Provider as soon as possible, but not later than seventy-two (72) hours after receiving the request for expedited appeal.

The written decision will include the same information that We would provide in the case of a Standard or non-expedited Appeal.

When the expedited appeal is a concurrent review determination, We remain liable for the coverage of health care services until You have been notified of the determination. We do not provide expedited reviews for retrospective non-certifications.

We may request additional information needed to make the determination within twenty-four (24) hours after receipt of the request. You are permitted forty-eight (48) hours to provide the additional information. We will make a determination within (48) hours of receiving the additional information or within (48) hours of the expiration of the time provided to You to submit the information, whichever is sooner.

Independent External Review

Independent External Review Process

North Carolina law provides for review of noncertification decisions by an external, Independent Review Organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to You, arranging for an IRO to review Your case once the NCDOI establishes that Your request is complete and eligible for review. You or someone You have authorized to represent You may request an external review. We will notify You in writing of Your right to request an external review each time You:

- receive a noncertification decision, or
- receive an appeal decision upholding a noncertification decision; or
- receive a second-level grievance review decision upholding the original noncertification.

In order for Your request to be eligible for external review, the NCDOI must determine the following:

- that Your request is about a medical necessity determination that resulted in a noncertification decision;
- that You had coverage with Us in effect when the noncertification decision was issued;
- that the service for which the noncertification was issued appears to be a covered service under Your policy; and
- that You have exhausted Our internal review process as described below.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

For a standard external review, You will be considered to have exhausted the internal review process if You have:

- completed Our appeal process and received a written determination on the appeal from Us;
- filed a an appeal and except to the extent that You have requested or agreed to a delay, have not received Our written decision within 60 days of the date can demonstrate that a grievance was filed with the insurer, or
- received notification that We have agreed to waive the requirement to exhaust the internal appeal.

If Your request for a standard external review is related to a retrospective noncertification (a noncertification which occurs after You have received the services in question), You will not be eligible to request a standard review until You have completed Our internal review process and received a written final determination from Us.

If You wish to request a standard external review, You (or Your representative) must make this request to NCDOL within 120 days of receiving Our written notice of final determination that the services in question are not approved. When processing Your request for external review, the NCDOL will require You to provide the NCDOL with a written, signed authorization for the release of any of Your medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of Your request for a standard external review, the NCDOL will notify You and Your provider of whether Your request is complete and whether it is accepted. If the NCDOL notifies You that Your request is incomplete, You must provide all requested additional information to the NCDOL within 150 days of the date of Our written notice of final determination. If the NCDOL accepts Your request, the acceptance notice will include:

- the name and contact information for the Independent Review Organization (IRO) assigned to Your case;
- a copy of the information about Your case that We have provided to the NCDOL;
- notice that We will provide You or Your authorized representative with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO); and
- notification that You may submit additional written information and supporting documentation relevant to the initial noncertification to the assigned IRO within 7 after receipt of the notice of acceptance.

If You choose to provide any additional information to the IRO, You must also provide that same information to Us at the same time using the same means of communication (e.g., You must fax the information to Us if You faxed it to the IRO). When faxing information to Us send it to (844) 202-2154. If You choose to mail Your information, send it to:

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

Please note that You may also provide this additional information to the NCDOL within the 7-day deadline rather than sending it directly to the IRO and Us. The NCDOL will forward this information to the IRO and Us within 2 business days of receiving Your additional information.

The IRO will send You written notice of its determination within 45 days of the date the NCDOL received Your standard external review request. If the IRO's decision is to reverse the noncertification, We will, reverse the noncertification decision within 3 business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the noncertification decision. If You are no longer covered by Us at the time We receive notice of the IRO's decision to reverse the noncertification, We will only provide coverage for those services or supplies You actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

An expedited external review of a noncertification decision may be available if You have a medical condition where the time required to complete either an expedited internal appeal or second level grievance review or a standard external review would reasonably be expected to seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function. If You meet this requirement, You may make a written or verbal request to the NCDOL for an expedited review after You:

- receive a noncertification decision from Us and file a request with Us for an expedited appeal, or
- receive an appeal decision upholding a noncertification decision.

You may also make a request for an expedited external review if You receive an adverse first-level appeal decision concerning a noncertification of an admission, availability of care, continued stay or emergency care, but have not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOL will review Your request and determine whether it qualifies for expedited review. You and Your provider will be notified within 2 days if Your request is accepted for expedited external review. If Your request is not accepted for expedited review, the NCDOL may: (1) accept the case for standard external review if Our internal review process was already completed, or (2) require the completion of Our internal review process before You may make another request for an external review with the NCDOL. An expedited external review is not available for retrospective noncertifications.

The IRO will communicate its decision to You within 3 business days of the date the NCDOL received Your request for an expedited external review. If the IRO's decision is to reverse the noncertification, We will, within one day of receiving notice of the IRO's decision, reverse the noncertification decision for the requested service or supply that is the subject of the noncertification decision. If You are no longer covered by Us at the time We receive notice of the IRO's decision to reverse the noncertification, We will only provide coverage for those services or supplies You actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

The IRO's external review decision is binding on Us and You, except to the extent You may have other remedies available under applicable federal or state law. You may not file a subsequent request for an external review involving the same noncertification decision for which You have already received an external review decision.

For further information about External Review or to request an external review, contact the NCDOL by mail at:

NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
(fax)919-807-6865

Or In Person at:

NC Department of Insurance
Albemarle Building
325 N. Salisbury Street
Raleigh, NC 27603
855-408-1212 (toll-free)

Visit www.ncdoi.com/Smart for External Review information and Request Form.

The Health Insurance Smart NC Program is also available to provide assistance to consumers who wish to file an appeal or grievance with their health plan.

Section 14 - Information on Policy and Rate Changes

Changes to this Policy

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

Changes In Covered Persons

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

Changes to Premium Charge

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

Misstatement of Age

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

Address Changes

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

Guaranteed Renewable

Guaranteed renewable means that this policy will renew each year on the anniversary date unless terminated earlier in accordance with policy terms listed in Section 12 – Termination/Nonrenewal/Continuation.

Renewal of Policy

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

Section 15 - Definitions

Adverse Determination or Denial means:

- A denial of a Pre-authorization for covered Benefits;
- A denial of a request for Benefits because 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 that is not due to the 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 covered services on the grounds that the treatment or service is experimental or investigational.

Allowable Amount - the maximum amount determined by Us to be paid to a Provider for Covered Health Services.

Alternate Facility - a health care facility that provides outpatient health care 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 support the work of the primary physician that is treating You.

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 - 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.

Behavioral Therapy – interactive therapies derived from evidence-based research, including applied behavior analysis. Behavioral Therapy includes discrete trial training, pivotal response training, intensive intervention programs and early intensive behavioral intervention.

Benefits - Your right to payment for Covered Health Services that are available under this Policy.

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 drug sold by a drug company under a specific name or trademark and that is protected by a patent. Brand name drugs may be available by prescription or over the counter.

Bright Health Company of North Carolina – means Bright Health Company of North Carolina, a health maintenance organization (HMO) which is organized under the laws of the State of North Carolina.

Chemically Equivalent –Prescription Drug Products that contain the same active ingredient for the treatment of an illness or symptom.

Child - means a person who is under the age of 26 and is the Subscriber or Dependent's:

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

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

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

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

Child-Only Policy – a Policy for a child or children under the age of 21, and when a parent or legal guardian is not enrolled in the Policy.

Chiropractic Services –treatment of neck and back pain through nonsurgical and noninvasive care that is within the scope of chiropractic practice.

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

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

Complications of Pregnancy - conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. .

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

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

Congenital Anomaly - something that is unusual or different at the time of a person's 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 and do not improve physiological function.

Covered Health Service(s) - Medically Necessary health care services that are covered by the Plan and provided for the purpose of diagnosing or treating an illness, injury or associated symptoms. Covered Health Services are:

- 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.

Creditable Coverage - means accepted health insurance coverage that You had prior to enrolling in this policy. Coverage may have been group health insurance, an employee welfare benefit plan to the extent that the plan provides medical care to employees and/or their dependents directly or through insurance, reimbursement, or otherwise, individual health insurance, short-term limited duration health insurance coverage, public health plan, Children's Health Insurance Program (CHIP), Medicare, Medicaid, and any other coverage defined as Creditable Coverage under state or federal law. Creditable Coverage does not include coverage consisting solely of excepted benefits.

Custodial Care - non-medical care that helps people with their activities of daily living.

Custom-Molded Shoes - shoes constructed over a positive model of the member's foot; made from leather or other suitable material of equal quality; have removable inserts that can be altered or replaced as the member's condition warrants; and have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.

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.

Denial or Adverse Determination means:

- A denial of a Pre-authorization for covered Benefits;
- A denial of a request for Benefits because 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 that is not due to the 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 covered services on the grounds that the treatment or service is experimental or investigational.

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

Depth Shoes - the shoe has a full length, heel-to- toe filler that, when removed, provides a minimum of 3/16th inch of additional depth used to accommodate custom-molded or customized inserts; are made of leather or other suitable material of equal quality; have some sort of shoe closure; and are available in full and half sizes with a minimum of three widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard sizing schedule or its equivalent.

Designated Beneficiary – a person selected by the Subscriber of a Policy as the decision-maker on the Policy in the event the Subscriber is unable to make such decisions.

Designated Beneficiary Agreement – an agreement between two unmarried people about legal rights, benefits, and protections under a Policy. The agreement allows the two people to make certain decisions about each other's health care and estate administration. The agreement may also allow decisions regarding treatment in medical emergencies, during incapacity, and at death.

Designated Pharmacy – a pharmacy that is contracted with Us to provide specific Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Domestic Abuse – means physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate, and intimidate, or to undermine the victim's ability to reason independently. All the facts and circumstances are considered in determining whether an individual is abused, including the effects of alcohol or drug abuse by the victim's Spouse. Depending on the facts and circumstances, abuse of the victim's child or another family member living in the household may constitute abuse of the victim.

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 who meets the Plan's guidelines and is eligible to enroll in a Policy offered by Us.

Emergency Ambulance Services – services provided by an ambulance service following the onset of a medical condition that manifests itself by symptoms of pain, illness or injury that the absence of accessing an ambulance or emergency response by 911 or a designated telephone number to reach a public safety answering point and receiving time sensitive medical attention could reasonably be expected to result in any of the following:

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

Emergency Medical Condition - a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

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

Emergency Services - health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

Enrolled Dependent – An eligible Child or Spouse who enrolled in this Policy.

Exchange, also known as the Marketplace, or Healthcare.gov - is a transparent and competitive online insurance marketplace where people 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.

Explanation of Benefits (EOB) – a statement sent to the Subscriber or enrolled Dependent following the payment of a claim by Us. An EOB lists services provided, the amounts applied to Deductible and the amounts paid by Us. The EOB will also indicate the amount the member may owe for services.

Facility – a hospital or free-standing surgical center where health care services are provided on an inpatient or outpatient basis.

Family Annual Deductible – the amount that a family enrolled in a Plan must pay towards any Allowed Amounts for Covered Health Services incurred in a calendar year, before We will begin paying for Benefits. On Our plans, this amount is equal to two times the Annual Deductible for an individual.

Formulary/Formulary Drugs – A list of medications covered by Us. Products that are on the Formulary generally cost less than products that are not on the Formulary.

Generic - a prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

Habilitative Services - health care services that help You keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language

pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Hearing aid - 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 – an exam or test that determines 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.

Infertility – the inability after 12 consecutive months of unsuccessful attempts to conceive a child despite regular exposure of female reproductive organs to viable sperm.

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

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

Inpatient Rehabilitation Facility - a facility that provides rehabilitative health services 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 by Us 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 – modified low protein foods and 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;
- Essential to a person's optimal growth, health and metabolic homeostasis;
- 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.

Medical Practitioner - includes but is not limited to a Physician, nurse anesthetist, physician's assistant, physical therapist, or midwife. With regard to medical services provided to a member, a medical practitioner must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically Necessary/Medical Necessity – means those covered services or supplies that are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and except as allowed for clinical trials under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes;
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms;
- Within generally accepted standards of medical care in the community; and
- Not solely for the convenience of the member, the member's family, or the provider.

For Medically Necessary services, nothing in this definition precludes Us from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

Medicare - a federal health insurance program for people 65 and older and certain Younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

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.

Musculoskeletal – any function of the musculoskeletal system that is integrated with neurological function and is expressed by biological regulatory mechanisms.

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 or Network Health Care Professional - means a provider that has an effective contract to provide services under their specific discipline (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-Preferred Prescription Drug - a drug designated by Us as Non-Preferred on Our Formulary. Non-Preferred Prescription Drugs may be brand name drugs or non-preferred generic drugs.

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 most You have to pay for covered services in a calendar year. After You spend this amount on deductibles, copayments, and coinsurance, Your health plan pays 100% of the costs of covered benefits.

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 - a person who is recognized and licensed under the laws of the state where treatment is received as qualified to treat the type of injury or illness for which a claim is made; and

- Is practicing within the scope of his or her license; and
- Is a duly licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.), or other Health Professional not specifically named in this Policy for whom reimbursement is mandated under applicable state or federal law, when licensed in the state where services are received.

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 agreement issued to the Subscriber that includes all of the following:

- This Policy, which includes the Schedule of Benefits.
- The enrollment application.
- Amendments.

Pre-authorization – a decision by Us that health care services are Medically Necessary. We may require preauthorization for certain services before You receive them, except for an Emergency Medical Condition. Preauthorization isn't a promise that We will cover the cost.

Preferred Brand Prescription Drug - a drug designated by Us as Preferred on Our Formulary. Preferred Brand Prescription Drugs may be brand name drugs or non-preferred generic drugs.

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 - drugs and medications that require a prescription, by law.

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 and Wellness Services – are routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

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 directly provides or coordinates a range of health care services for a patient.

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.

Rehabilitative Services - health care services that help You keep, get back, or improve skills and functioning for daily living that have been lost or impaired because You were sick, hurt, or disabled.

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 a retail store or pharmacy 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 geographic area where a the Plan accepts members. For plans that limit which doctors and hospitals You may use, it's also generally the area where You can get routine (non-emergency) services. The plan may end Your coverage if You move out of the plan's service area.

Sexual Dysfunction – any group of sexual disorders characterized by inhibition either of sexual desire or the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder, and hypoactive sexual desire disorder.

Sickness - a particular type of illness or disease.

Skilled Nursing Facility - an inpatient healthcare facility that provides skilled care, rehabilitation and other related health services to patients who need nursing care, but do not require hospitalization.

Specialist Physician - a Physician that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

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.

Spousal Abandonment – means a taxpayer is a victim of spousal abandonment for a taxable year if, taking into account all facts and circumstances, the taxpayer is unable to locate his or her spouse after reasonable diligence.

Spouse – Your legal Spouse, common-law Spouse, partner in a civil union, Domestic Partner or Designated Beneficiary.

Stabilize - to provide medical care that is appropriate to prevent a material deterioration of a person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred.

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.

Therapeutic Equivalence - when Prescription Drugs can be expected to produce essentially the same outcome in treating an illness or symptom.

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 care facility that treats injuries or illnesses that require care right away, but that are not serious enough to require an emergency room visit.

Usual and Customary Charge - is the base amount for the standard or most common charge for a medical service in a specific geographic region.

Utilization Review – is a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Areas of review may include prospective review, concurrent review or retrospective review. Case management and Prior Authorization are also types of Utilization Review.