Bright HealthCare™

2022
Certificate of Coverage

BrightHealthCare.com

Section 1 – Title Page (Cover Page)
Individual Major Medical Health Insurance Policy

Plan Name: Bright Health Insurance Company

Member Name: **Coverage Effective Date:** **Premium Amount:**

Bright HealthCare
PO BOX 1519
Portland, ME 04104
Phone: (844) 926-4524, TTY 711
Web: www.brighthealthcare.com

This document includes important information that describes Your Policy. Your Policy is a legal contract between the Subscriber and Bright Health Insurance Company "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. The consideration for issuance of the Policy is the applicant's application and the first premium payment.

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This policy was issued based on the information entered in your application, a copy of which is attached to the policy. If you know of any misstatement in your application, you should advise Us immediately regarding the incorrect or omitted information; otherwise, your policy may not be a valid contract.

Right to Return Policy Within 10 Days
If for any reason You are not satisfied with Your Policy, You may return this Policy to Us within ten days of the date You received it and the Premium You paid will be promptly refunded.

Guaranteed Renewable/Premium Subject to Change
Your plan is guaranteed renewable at Your option, except when:

- You have failed to make timely Premiums, or
- You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage, or
- We are ceasing to offer coverage in the individual market, or
- You no longer reside, live, or work in the Service Area or an area in which We are authorized to do business (coverage will be terminated under this section uniformly without regard to any health status-related factor of Covered Individuals).

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.

This Policy is not a Medicare Supplement Policy
If You are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from Us.

Entire Contract
This Policy includes Your:

- Schedule of Benefits
- Enrollment Application

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

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

Payor of Last Resort
The Department of Medical Assistance Services is the payor of last resort. Please note that Bright Health will not exclude enrolling an individual or in making any payment for benefits to an individual or on an individual's behalf for health care when the individual is eligible for medical assistance.

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" refer to the Responsible Adult.

BRIGHT HEALTH

Simeon Schindelman
Chief Executive Officer

Section 2 – Contact Us

Please contact Us for more Information.

Questions About Your Benefits

Customer Service:
(844) 926-4524
TTY: 711

On Our Website at:
www.brighthealthcare.com

Send Claims or other written correspondence to Us at:

Bright HealthCare
P.O. Box 1519
Portland, ME 04104

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the *Contact Us* information listed above.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Toll free phone: 1-877-310-6560,
Toll free in state calls: 1-800-552-7945
Mailing address: Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Nondiscrimination Notice and Assistance with Communication

Bright Health does not exclude, deny benefits to, or otherwise discriminate against any individual on the basis of sex, age, race, color, national origin, or disability. “Bright Health” means Bright Health plans and their affiliates, which are listed below.

Language Assistance and Alternate Formats

Assistance is available *at no cost* to help You communicate with Us. Services include but are not limited to:

- Interpreters for languages other than English.
- Written information in alternative formats such as large print.
- Assistance with reading Bright Health websites.

For help with these services, please call the Member Services number on Your Member ID Card.

If You think that We failed to provide language assistance or alternate formats, or You were discriminated against because of Your sex, age, race, color, national origin, or disability, You can send a complaint to:

Bright Health Civil Rights Coordinator
P.O. Box 853943
Richardson, TX 75085-3943
Phone: (844) 202-2154
Email: OAG@brighthealthcare.com

You can also file a complaint with the U.S Dept. of Health and Human Services, the Office of Civil Rights:

- **Online**: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
- **Phone**: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
- **Mail**: U.S. Dept. of Health and Human Services, 801 Market Street, Suite 9300, Philadelphia, PA 19107

Language Assistance and Alternate Formats

This information is available in other formats like large print. To ask for another format, please call the Member Services number on your member ID card.

English	ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call the Member Services number on your ID card.
Spanish (US)	ATENCIÓN: Si usted habla español, tiene a su disposición servicios de asistencia de idioma gratuitos. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación.
Chinese (S)	注意：如果您讲中文，我们可以为您提供免费的语言协助服务。请拨打您ID卡上的会员服务电话号码。
Russian	ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните в Службу работы с клиентами по телефону, указанному в Вашей идентификационной карте.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. ID 카드에 있는 회원 서비스 번호로 전화하십시오.
Haitian Creole	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Sèvis Manm nan nimewo ki make sou kat ID ou an.
Italian	ATTENZIONE: se parla italiano, sono disponibili per Lei servizi di assistenza linguistica gratuiti. Chiami il numero dell'assistenza ai membri riportato sulla Sua scheda identificativa.
Yiddish	אויפמערקאזמקייט: אויב איר רעדט ייִדיש, עס זענען פאראן פאר אייך שפראך הילף סערוויסעס פריי פון אָפּצאָל. רופט די מעמבער סערוויסעס נומער אויף אייערע אייי־די קאַרטל.
Bengali	মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, তাহলে আপনার জন্য, ভাষা সহায়তা পরিষেবাগুলি, বিনামূল্যে উপলব্ধ আছে। আপনার ID কার্ডে থাকা সদস্য পরিষেবাগুলির নম্বরে ফোন করুন।
Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فيمكنك الاستعانة بخدمات المساعدة اللغوية بدون مقابل. اتصل برقم خدمات الأعضاء المدوّن على بطاقة التعريف الخاصة بك.
Polish	UWAGA: Jeżeli posługuje się Pan/ Pani językiem polskim, może Pan/ Pani skorzystać z bezpłatnej pomocy językowej. Prosimy zadzwonić do Działu Usług dla Członków, którego numer jest podany na Pana/ Pani karcie identyfikacyjnej.
French (FR)	REMARQUE : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le numéro des services aux membres, qui figure sur votre carte d'identification.
Tagalog	PANSININ: Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo para sa wika. Tawagan ang numero ng Mga Serbisyo sa Miyembro na nasa inyong ID kard.
Vietnamese	LƯU Ý: Nếu quý vị nói tiếng Việt, sẽ có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi số Dịch vụ Hội viên trên thẻ ID của quý vị.
Navajo	DÍÍ BAA AKÓ NÍNÍZIN: Díí Diné bizaad be yáníłti'go, saad bee áká'ánida'áwo' dęę', t'áá jiik'eh, ná hóló. Kojį' hódíílnih Member Servicesjį éí binumber naaltsoos nitł'izgo bee nee hódólzin biniiyé nantinígíí bikáá'
Urdu	توجہ دیں: اگر آپ اردو بولتے/بولتی ہیں، تو آپ کے لیے زبان سے متعلق اعانت کی خدمات، مفت دستیاب ہیں۔ اپنے آئی ڈی کارڈ پر موجود ممبر سروسز کے نمبر پر کال کریں۔
Japanese	注記：日本語をお話しになる方は、無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載のメンバーサービス電話番号までお電話ください。
Portuguese (BR)	ATENÇÃO: caso você fale português, há serviços gratuitos de assistência de idioma à sua disposição. Ligue para o número de Atendimento ao Associado, impresso no seu cartão de identificação.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie unter der auf Ihrer ID-Karte aufgeführten Telefonnummer für Mitgliederdienstleistungen an.
Persian Farsi	توجه: اگر زبان شما فارسی است، خدمات کمک زبانی به صورت رایگان در اختیار شماست. با «خدمات اعضا» که شماره آن روی کارت شناسایی شما درج شده است تماس بگیرید.

Amharic	ማሳሰቢያ: ከእንግሊዝኛ ውጪ የሆነ ቋንቋ የሚናገሩ ከሆነ ከክፍያ ነጻ የሆኑ የቋንቋ ድጋፍ አገልግሎቶችን ማግኘት ይችላሉ:: በመታወቂያ ላይ በሚገኝ የአባላት አገልግሎት ቁጥር ላይ ይደውሉ::
Burmese	သင့်သည် အင်္ဂလိပ်စကားမဟုတ်သော အခြားဘာသာစကားတစ်ခုအား ပြောဆိုသူဖြစ်ပါက ဘာသာစကားအခမဲ့ပံ့ပိုးသည့် ဝန်ဆောင်မှုအား သင့်ရရှိနိုင်ပါသည်။ သင့် ID (သက်သေခံ) ကတ်ပြားပေါ်ရှိ အဖွဲ့ဝင်များဝန်ဆောင်မှုဌာနအား ဖုန်းခေါ်ဆိုပါ။
Cherokee	ᎠᏓᏎᏍᏓ: ᏎᎢ ᎦᏬᏂᏍᎬ ᏱᏬᏂᎮ ᏏᏃ ᎩᏊᏏ, ᎦᏬᏂᎯᏍᏗ ᎠᏊᏍᏚᏊᏍᎬ ᎢᏗᏓᎾᏁᏗᎢ, Ꮳ ᎠᎱᏍᏗ ᏧᎬᎩᏛᏗ ᏱᏓ ᎠᏎᏇᎢ, ᏂᎯ ᏒᏣᏛᎥᎢᏍᏓᏁᎸᎢ. ᎾᏍᎩᏃ ᏥᏯᏫ ᏢᏊ ᎠᏊᏍᏚᏊᏍᎬ ᏗᏎᏍᏗ ᎤᎾᎢ ᏩᏤᏊ ᎠᏟᏍᏆᏗ ᏆᎾᏲᏍᏗ.
Cushite-Oromo	XIYYEEFFANNOO: Afaan Ingiliziin ala afaan kan biraa kan dubbattu yoo ta'e, tajaajilliwwan gargaarsa afaanii, kan tolaa, siif ni jiru. Kaardii Waraqaa-eenyummeessaa keerra kan jiru lakkoofsa Tajaajilawwan Miseensaatti bilbili.
French Creole	ATANSYON : Si w pale yon lòt lang ke Angle, gen sèvis èd lengwistik ki disponib pou w gratis. Rele nimewo Sèvis pou manm yo nan kat idantite w la.
Gujarti	ધ્યાન આપો: જો તમે અંગ્રેજી સિવાયની અન્ય કોઈ ભાષા બોલો છો, તો તમારા માટે ભાષા સહાય સેવાઓ નિ:શુલ્ક ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર રહેલા સદસ્યની સેવાઓનાં નંબર પર કૉલ કરો.
Hindi	ध्यान दें: यदि आप अंग्रेजी के अलावा कोई अन्य भाषा बोलते हैं, तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। आपके आईडी कार्ड पर दिए गए सदस्य सेवा नंबर पर कॉल करें।
Hmong	UA ZOO SAIB: Yog tias koj hais ib hom lus dhau ntawm lus As Kiv, muaj cov kev pab cuam txhais lus uas tsis xam nqi dab tsi rau koj tau siv. Hu rau Lub Chaw Pab Cuam Tswv Cuab tus nab npawb xov tooj nyob ntawm koj daim npav ID.
Karen	တိၢ်နိၣ် – နမ့်ကတိၤကျိာ်လၢတမ့်အဲကလံးကျိာ်ဘၣ်နှၣ်, ကျိာ်တၢ်တိစၢၤမၤစၢၤတၢ်မၤစၢၤတဖၣ်, လၢတလိၣ်ဟ့ၣ်အပ္ၤတဖၣ်အိၣ်လၢနဂီၢ်နှၣ်လီၤ. ကိးကရၢဖိတၢ်မၤစၢၤတဖၣ် (န့နၣ်ဘနမ့နမလၤငးနျ) အနီၣ်ဂံၢ်ဖဲန တၢ်အုၣ်သးနီၣ်ဂံၢ်စးက့အဖီခိၣ်နှၣ်တက့ၢ်.
Kru / Bassa	YI LE: I balè u mpot hop umpè èbes Ngissi, bot ba nhola ni kobol mahop bayé ha i nyuu yoñ, ngui nsaa wogui wo. Sebel Ndap Mahola i nyuu Mbon i nsinga i yé ntilgaga munu i Kat yon i Mbon.
Kurdish	ئاگاداری: ئەگەر بە زمانێکی تری جگە لە ئینگلیزی قسە دەکەیت، خزمەتگوزاریە زمانەوانیەکان بەخۆرایی بۆ تۆ بەدەستن. پەیوەندی بە ژمارەی خزمەتگوزاری ئەندامانی سەر ناسنامەکەت بکە.
Laotian	ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາອື່ນນອກຈາກພາສາອັງກິດ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາທີ່ບໍ່ເສຍຄ່າແມ່ນມີພ້ອມໃຫ້ທ່ານ. ກະລຸນາໂທຫາ ໝາຍເລກການບໍລິການສະມາຊິກທີ່ຢູ່ເທິງ ບັດ ID ຂອງທ່ານ.
Mon-Khmer	ចាប់អារម្មណ៍៖ ប្រសិនបើលោកអ្នកនិយាយភាសាផ្សេង ក្រៅពីភាសាអង់គ្លេស នោះសេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសម្រាប់លោកអ្នក។ សូមទូរស័ព្ទទៅលេខសេវាបម្រើសមាជិកដែលមាននៅលើកាតសម្គាល់របស់លោកអ្នក។
Nepali	ध्यान दिनुहोस्: यदि तपाइँ अङ्ग्रेजी बाहेक अन्य भाषा बोल्नुहुन्छ भने तपाइँको लागि निःशुल्क रूपमा भाषा सहायता सेवा उपलब्ध छ। तपाइँको आइडी कार्डमा भएको सदस्य सेवा नम्बरमा कल गर्नुहोस्।
Persian Farsi	توجه: در صورتی که به زبانی غیر از انگلیسی صحبت می کنید خدمات کمکی زبانی به طور رایگان برای شما وجود دارد. برای این منظور با شماره خدمات اعضای موجود روی کارت شناسایی خود تماس بگیرید
Serbo-Croatian	PAŽNJA: Ako govorite neki drugi jezik osim engleskog, dostupne su vam besplatne usluge za jezičnu pomoć. Pozovite broj službe za članove na vašoj ličnoj karti.
Syriac	ܙܘܗܪܐ: ܐܢ ܗܘ ܕܡܡܠܠܬ ܐܝܟ ܠܫܢܐ ܐܚܪܢܐ ܣܛܪ ܡܢ ܠܫܢܐ ܐܢܓܠܝܙܝܐ: ܗܘܝ ܝܕܥܐ ܕܐܝܬ ܬܫܡܫܬܐ ܕܡܥܕܪܢܘܬܐ ܠܫܢܝܬܐ ܕܠܐ ܐܓܪܐ. ܩܪܝ ܠܡܢܝܢܐ ܕܬܫܡܫܬܐ ܕܗܕܡܐ (Member Services) ܕܟܬܝܒ ܥܠ ܟܪܛܝܣ ܕܫܘܘܕܥܐ ܕܝܠܟ.
Thai	ข้อควรทราบ: หากคุณใช้ภาษาอื่นที่ไม่ใช่ภาษาอังกฤษ เรามีบริการความช่วยเหลือทางภาษาจัดให้แก่คุณโดยไม่คิดค่าใช้จ่ายใด ๆ ติดต่อหมายเลขให้บริการสมาชิกที่บัตรประจำตัวของคุณ
Turkish	DİKKAT: İngilizce haricinde bir dil konuşuyorsanız, dil yardım hizmetlerinden ücretsiz olarak faydalanabilirsiniz. Kimlik kartınızın üzerindeki numaradan Üye Hizmetlerini arayın.
Ukrainian	УВАГА: якщо ви не розмовляєте англійською, то можете скористатися безкоштовними послугами мовної підтримки. Зателефонуйте до Відділу обслуговування учасників програми за телефоном, вказаним на вашій ідентифікаційній картці.

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. We may assign a Primary Care Physician to You and notify You of the assignment. If Your choose to select a different Primary Care Physician, please notify Us.
- Have Your medical information kept confidential by Us and Your Physician. We honor the confidentiality of Covered Person information and adhere to all federal and state regulations regarding confidentiality and the protection of personal health information.
- Participate with Your health care professional in health care decisions and have Your health care professional give You information about Your medical condition and Your treatment options, regardless of coverage or cost. You have the right to receive this information in terms and language You understand.
- Learn about any care You receive. You should be made aware of any special programs or services that We have made available to assist You, as well as how to enroll, or change programs or services. You should be asked for Your consent for all care unless there is an Emergency and Your life and health are in serious danger.
- Refuse medical care and disenroll from programs/services offered by Us. If You refuse medical care, Your health care professional should tell You what might happen. We urge You to discuss Your concerns about care with Your Primary Care Physician or other participating health care professional. Your Physician or health care professional will give You advice, but You will have the final decision.
- Be heard. Our complaint-handling process is designed to hear and act on Your complaint or concern about Us and/or the quality of care You receive from health care professionals and the various places You receive care in Our network, provide a courteous, prompt response, and guide You through Our appeal process if You do not agree with Our decision.
- Make recommendations regarding Our policies that affect Your rights and responsibilities.

You Have the Responsibility to:

- Pay Your monthly Premium including any outstanding Premium due as a result of a retroactive changes to Your Policy on or before the due date.
- Review and understand the information You receive about Your health Benefit plan. Please call Customer Service when You have questions or concerns.
- Understand how to obtain services and supplies that are covered under Your plan.
- Show Your ID Card before You receive care.
- Schedule a new patient appointment with any Network Provider; build a comfortable relationship with Your Physician; ask questions about things You don't understand; and follow Your Physician's advice. You should understand that Your condition may not improve and may even get worse if You don't follow Your Physician's advice.
- Understand Your health condition and work with Your Physician to develop treatment goals that You both agree upon.
- Provide honest, complete information to the health care professionals caring for You.
- Know what medicine You take, and why and how to take it.

- Pay all Copayments, Annual Deductibles, and Coinsurance for which You are responsible, at the time service is rendered or when they are due.
- Keep scheduled appointments and notify the health care professional's office ahead of time if You are going to be late or miss an appointment.
- Pay all charges for missed appointments and services 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 3 – Table of Contents

Section 4 – Eligibility

We offer of Individual Policies which include coverage for at least one person and coverage for Eligible Dependents.

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:

- Live in the Service Area (if You or an Enrolled Dependent live outside the Service Area and incur health care services, You may be subject to higher out-of-pocket expenses).
- Not be enrolled in Medicare Parts A, B and/or D on Your effective date of coverage with Us. It is unlawful for Us to knowingly issue an individual market Policy to You if You are enrolled in Medicare on Your effective date. If We have knowledge of Your enrollment in Medicare, We will not issue a Policy to You..

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

- A Spouse as defined in the *Definitions* section of this Policy
- 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 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.

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

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

- An individual involuntarily loses existing minimal essential 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 child support or other court order.

- 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 minimal essential coverage as a result of a permanent change of residence,
- A parent or legal guardian dis-enrolling a Dependent, or a Dependent becoming ineligible for the Children's Basic Health Plan.
- An individual becoming ineligible under Medicaid or the Children's Health Insurance Program.
- An individual who was not previously a citizen, national, or 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.
- Victims or dependent of victim of domestic abuse or spousal abandonment.
- An individual who is newly released from incarceration.
- Exceptional circumstance, as determined by the Secretary of HHS, including being incapacitated or experiencing a natural disaster.
- Any other event or circumstance occurs as set forth in rules from the Virginia Bureau of Insurance that defines triggering events.

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

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

A dependent newborn Child of the Subscriber is covered from the moment of birth. The newborn child must be enrolled on the Policy within 31 days after the date of birth for coverage to continue beyond the initial 31-day period. 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 responsibility for the newborn after the initial 31 days of coverage.

Newly adopted Children, including Children newly placed for adoption, shall be considered a newborn Child of the Subscriber, if the adoption or parental placement has occurred within 31 days of birth. The effective date of coverage is the date of the adoption or placement for adoption. An eligible adopted Child must be enrolled within 31 days from the date the Child is placed in the 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 responsibility for the adopted Child.

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

Dependents who are not enrolled when newly eligible must wait until the next Open Enrollment Period to enroll unless they enroll under the provisions described in the special enrollment period

section described above. Open enrollment is the yearly period for which people may enroll for health insurance.

If You Are Hospitalized When Your Coverage Begins

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

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

Section 5 – How to Access Services and Obtain Approval of Benefits

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

This is a Network Only Plan

This plan uses 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 receiving care at a Network Facility.
- We authorize services out-of-network because the Medically Necessary services that You need are not available from a Participating Provider.

You can review Our provider network online at www.brighthealthcare.com or contact Customer Service at the telephone number listed in the *Contact Us* section of this Policy and on Your ID card to obtain a copy of Our Provider Directory.

Choose Your Physician from Our Network of Participating Providers

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

Participating Providers are listed on Our website at www.brighthealthcare.com or You can contact Customer Service at the telephone number listed in the *Contact Us* section of this Policy and on Your ID card to obtain a copy of Our Provider Directory.

Participating Providers are subject to a credentialing process in which 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 Provider's services. Providers and facilities are solely responsible for the care they deliver.

Before obtaining services, You should always verify if the Provider is a Participating Provider. A provider's contracted status may change. You can verify if the provider is still in Our Network online at www.brighthealthcare.com or by calling Customer Service at the telephone number listed in the *Contact Us* section of this Policy and on Your ID card.

If you find that a particular Network Provider is not accepting new patients, or that the provider has left the Network, You must choose a different Participating Provider.

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

This plan allows You to:

- Choose from Our Network of Participating Providers and Hospitals for Your health care needs.
- Have direct access to eye care providers, Mental Health care providers, pediatricians, obstetrical or gynecological health care professionals. You do not need Prior Authorization from the plan or from any other person (including a Primary Care Physician) in order to obtain access to Mental Health, obstetrical, or gynecological care from a health care professional in Our network who specializes in those types of services. The health care professional, however, may be required to comply with certain provisions related to 1) obtaining Prior Authorization, and 2) following a pre-approved treatment plan. For a list of

participating health care professionals who specialize in eye care, Mental Health, and obstetrics or gynecology, visit Our website at www.brighthealthcare.com or call Customer Service at the number listed in the *Contact Us* section of this Policy and on Your ID card. Take advantage of significant cost savings when You use doctors contracted with Us.

Transition of Care (When You Are A new Member and Wish to Continue Receiving Care From a Non-Network Provider)
Transition of Care allows You to continue to receive services for specified medical and behavioral conditions for a defined period of time with doctors, Hospitals, and Providers who are Non-Network until the safe transfer of care to a Network Provider can be arranged.

You should apply for Transition of Care within 30 days from the time Your policy becomes effective. Requests will be reviewed within 10 days of receipt. Organ transplant requests will be reviewed within 30 days of receipt.

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

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

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

- Routine exams, vaccinations, health assessments.
- Chronic Conditions such as, arthritis, allergies, asthma, glaucoma, depression and anxiety, etc.
- Elective scheduled surgeries such as removal of lesions, arthroscopies, hernia repairs, 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 Customer Service at the telephone number listed in the *Contact Us* section of this Policy and on Your ID Card.

Continuity of Care (When Your Provider Leaves Our Network)
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 should apply for Continuity of Care within 30 days of Your Network Provider leaving Our Network. Requests will be reviewed within 10 days of receipt. Organ transplant requests will be reviewed within 30 days.

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, for continuation of Covered Health Services rendered by the terminated Provider for the time periods shown below. Copayments, Deductibles, or other cost sharing components will be the same as You would have paid for a Provider currently contracting with Us.

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

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

- Terminally ill. Treatment may continue for the remainder of the Enrollee's life for care directly related to the treatment of the terminal Illness.

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.

For information on how to apply for Continuity of Care, contact Customer Service at the telephone number listed in the *Contact Us* section of this Policy and on Your ID Card.

You can obtain a listing of Network Providers on Our website or by contacting Customer Service at the telephone number listed in the *Contact Us* section 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 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. Contact Customer Service at the number listed in the *Contact Us* section of this Policy and on Your ID Card for the location of the office nearest You.

Designated Facilities and Other Providers
If You have a medical condition that We believe needs special services, We may direct You to a Designated Facility or Designated Physician chosen by Us. If You require certain complex Covered Health Services for which expertise is limited, We may direct You to a Network facility or provider that is outside Your Service Area. If You are required to travel to obtain such Covered Health Services from a Designated Facility or designated Physician, We may reimburse certain travel expenses at Our discretion. Please refer to Section 6 - Benefits/Coverage, for more information about eligible Travel Expenses.

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 Prior authorization terms of this Policy.

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

Receiving Non-Emergent Care From Non-Network Providers
There are specific situations when this plan will cover non-emergent services from Non-Network Providers.

Non-emergent services from Non-Network Providers are covered by the plan when You are treated by a Non-Network Provider while you are receiving care at a Network facility. You will not be responsible for any payments beyond the Copayment, Deductible and Coinsurance amounts that You would have paid had You received services from a Network Provider.

Non-emergent services from Non-Network Providers may be covered by the plan when We approve an authorization request for Medically Necessary care to a Non-Network Provider because the care is not available from a Participating Network Provider. The payment for these services is subject to using the authorized Provider, Your eligibility at the time of service, and the benefit limitations outlined in Section 7 – Limitations/Exclusions (What is Not Covered). If We do not have a Network Provider or specialist within Our network to provide services for a covered benefit, We may issue Prior authorization to see a Non-Network Provider. You will not be denied Medically Necessary care in this instance. If this occurs, You will not be responsible for any payments beyond

the Copayment, Deductible and Coinsurance amounts that You would have paid had You received services from a Network Provider.

Non-Network Providers are not contracted with Us. If You access services from a Non-Network Provider for non-emergency Health Services and You did not have Prior Authorization from Us, the services will not be covered. You will be responsible for the entire amount that the Provider bills.

Receiving Emergency Care From Network Providers or Network Facilities
When receiving Medically Necessary Emergency Health Services from a Participating or Network facility, You will be responsible for Your Network Deductible, Copayment or Coinsurance amounts as indicated in Your Schedule of Benefits.

Receiving Emergency Care From Non-Network Providers or Non-Network Facilities
When receiving care that qualifies as Emergency Health Services from a Non-Network Provider in a Non-Network facility, payment from the plan will be the greater of:

- The median amount negotiated with Network Providers for the emergency service.
- Usual, Reasonable and Customary charges based on the geographic region.
- The amount negotiated by Us for the charges; or
- The amount that would be paid under Medicare for the Emergency Health Services.

You will not be responsible for any payments beyond the Copayment, Deductible, and Coinsurance amounts that You would have paid had You received services from a Network Provider.

Prior Authorized Care From Non-Network Providers
In a case where We do not have a Network Provider or specialist within Our network to provide services for a covered Benefit, We will issue Prior Authorization to see a Non-Network Provider. You will not be denied Medically Necessary care or charged additional expenses because use of a Non-Network Provider is required. You will be responsible for Your Network Deductible, Coinsurance, or Copayment amounts.

Payment for Charges to Non-Network Providers
If You receive care from a Non-Network Provider, You may be required to pay to that Provider at the time of service. To be considered for reimbursement for what You have paid, You will need to provide Us with an itemized bill.

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

- Name and address of the Physician or other health care Provider, Tax ID Number, NPI Number.
- Full name, address, and date of birth of the patient receiving treatment or services.
- 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. If payment is sent to You for a claim for services received by a Non-Network Provider, You are responsible for applying the claim payment to the applicable Non-Network Provider.

Claims for services rendered by a Non-Network 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.

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

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

Following evaluation and validation of certain provider billings (e.g., error, abuse, and fraud reviews), Our reimbursement policies are applied to provider billings.

Network Providers are contractually obligated to follow Our reimbursement policies and may not bill You for the balance.

Services provided by a Non-Network Provider at a Network facility will be reimbursed according to Network reimbursement policies. You will not be responsible for any payments beyond the Copayment, Deductible and Coinsurance amounts that You would have paid had You received services from a Network Provider.

Emergency Health Services received from a Non-Network provider will be reimbursed at the greater of:

- The median amount negotiated with Network Providers for the emergency service.
- Usual, Reasonable and Customary charges based on the geographic region.
- The amount that would be paid under Medicare for the Emergency Health Services.

You will not be responsible for any payments beyond the Copayment, Deductible and Coinsurance amounts that You would have paid had You received services from a Network Provider.

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

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

Alexandria City	Arlington	Amelia	Culpeper
Caroline	Charles City	Chesterfield	Colonial City
Cumberland	Dinwiddie	Fairfax	Fairfax City
Falls Church City	Fauquier	Goochland	Hanover
Henrico	Hopewell City	King and Queen	King William
Loudoun	Louisa	Madison	Manassas City
Manassas Park City	New Kent	Prince William	Petersburg City
Powhatan	Prince George	Richmond City	Spotsylvania
Sussex			

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

Health Services will be covered as Network Benefits regardless of the provider's Network status or Service Area.

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

See Our Provider Directory at www.brighthealthcare.com for a list of Network Providers in the Service Area or contact Customer Service at the telephone number listed in the *Contact Us* section of this Policy and on Your ID Card for assistance.

Medically Necessary Services

Understanding what Medically Necessary 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 Medically Necessary as health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

We use several types of information in making decisions about what is Medically Necessary.

- Effectiveness is determined by, but not limited to:
  - Scientific evidence, medical literature, and other evidence-based guidelines
  - Consideration of cost-effectiveness compared to alternative interventions, including no intervention
  - Expert Opinion
  - Professional organization practice guidelines
  - State and federal regulatory agencies
  - Managed care industry standards
  - Technology assessment information services

Second Opinions

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

Prior Authorization

Prior Authorization is the process of reviewing a request for health care services prior to receiving care. Prior Authorization may be required to make sure services are Medically Necessary, and that the Provider is Network. Please refer to Your Schedule of Benefits to see which services require Prior authorization.

Who is Responsible for Obtaining Prior Authorization?

If You are receiving care from a Network Provider, the Network Provider is responsible for obtaining Prior Authorization before they provide these services to You. If the Provider fails to obtain Prior Authorization and the service is denied, the Provider may not bill You for the balance.

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

Through the Prior Authorization process, You may qualify for specialty programs which include but are not limited to the:

- Provision of informed decision-making materials;
- Provision of information on how to choose higher quality, lower cost centers, or providers; access to special care Success programs; and
- Assignment of a case or disease management professional to assist You in evaluating and understanding health care choices.

Failure to obtain the Prior Authorization prior to receiving care may result in services not being covered, regardless of the circumstances or reason why Medically Necessary .

The Prior Authorization review process requires the full cooperation of the requesting Physician in order for Us to evaluate all of the pertinent information and make a coverage determination. We must make Our decision within 15 calendar 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 calendar days for a decision. If Your request to expedite is granted, We must give You a decision within 72 hours after We receive the supporting statement from Your Physician. The timeframe for making a coverage determination may be extended if the Prior Authorization request lacks sufficient information or if there is a situation beyond Our control (for example, severe weather or declaration of a state of emergency).

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

If the Prior Authorization process is not followed, it could result in the delay of claims payments.

Requests for retrospective authorization Prior Authorization of services more than 180 days after the date of service will be denied.

Utilization Management

When We receive a request for Prior Authorization of health care services, We may work with You through the utilization management process. We may also refer you to Care Management for information about additional services available to You, such as disease management programs, health education, and patient advocacy.

All Utilization Management decisions are made by qualified licensed professionals trained to assess clinical information used to support Care Management decisions. Our decision-making is based only on appropriateness of care and service and existence of coverage. There are no financial incentives that encourage decisions that result in underutilization. We do not reward practitioners, referring Physicians, or other utilization 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. We make determinations of benefits according to whether they are Medically Necessary , the provider's or facility's network status, and whether or not the service(s) are a Covered Health Service under Your plan.

Show Your ID Card

You should show Your ID Card every time You request health services. If You do not show Your ID Card, the Provider may 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 owed to You. The billing address used is based on the plan under which Your coverage is issued. Therefore, it is important that You verify that Your Provider has the correct billing information on file for Your plan.

Member Cost Sharing Requirements

Cost-sharing amounts include Deductibles, Coinsurance, Copayments, and any other expense required of a Member. Depending on the type of care You receive, and where You receive care, Your cost-sharing amounts will differ.

Refer to the Schedule of Benefits to determine Your cost-sharing requirements.

Annual Deductible is 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. Deductible amounts accumulate towards Your Out-of-Pocket Maximum.

Coinsurance is the percentage of any Allowed Amount that You are required to pay for certain Covered Health Services. Coinsurance amounts accumulate towards Your Out-of-Pocket Maximum.

Copayments are the charges stated as a set dollar amount that You are required to pay for certain Covered Health Services. Copayment amounts accumulate towards Your Out-of-Pocket Maximum.

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

All Deductible, Copayment and Coinsurance payments for Network Covered Health Services will apply to the Out-of-Pocket Maximum. When calculating a Covered Person's overall contribution to any Out-of-Pocket Maximum or any cost sharing requirement, We shall include any amounts paid by the Covered Person or paid on behalf of the Covered Person by another person, to the extent permitted by federal law and regulation. Once the Out-of-Pocket Maximum 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.

For policies with two or more people, each person's Individual Out-of-Pocket Maximum applies to the Family Out-of-Pocket Maximum. Once a Covered Person has met his or her Out-of-Pocket Maximum, the Covered Person will have no further obligation to pay charges for Network Covered Health Services for the remainder of the Plan Year. Once two (2) or more people's combined Out-of-Pocket expenses reach the Family Out-of-Pocket Maximum, Covered Persons under the Family policy will have no further obligation to pay charges for Network Covered Health Services.

Section 6 – 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.

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 of any 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. Refer to the Schedule of Benefits for details about:

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

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

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

Covered Health Services
Refer to the *How to Access Your Services and Obtain Approval of Benefits* section to determine whether services listed below require Prior Authorization.

Accidental Injury Dental Services
Outpatient Services, Physician Home Visits and Office Services, Emergency Care, and Urgent Care services received at an Urgent Care Center for dental work and oral surgery includes:

- Medically Necessary dental work resulting from an accidental injury, excluding an injury resulting from chewing or biting.
- Repair of dental appliances damaged in accidental injury to jaw, mouth or face.
- Dental appliances needed to treat an accidental injury to the teeth.

- Dental services, including x- rays, extractions, and anesthesia to prepare the mouth for medical treatments, such as radiation therapy to treat cancer and prepare for transplants are covered.

"Initial" dental work to repair injuries due to an accident means services are performed within 12 months from the Injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a Child requiring facial reconstruction due to dental related Injury, there may be several years between the accident and the final repair.

Covered Services for accidental Injury dental services include, but are not limited to:

- Anesthesia
- Mandibular/Maxillary reconstruction
- Oral examinations
- Oral surgery
- Prosthetic services
- Restorations
- Tests and laboratory examinations
- Tooth Reimplantation and/or Stabilization due to accident
- X-rays

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.

Allergy Testing and Treatment
Covered Services include testing and treatment, allergy shots, and allergy serum.

Ambulance Services/Emergency Transportation
Covered Health Services under this section include:

- Professional ambulance services by a licensed ambulance service to the nearest Hospital where Emergency health services can be adequately performed. Air emergency transportation by fixed wing or rotary wing is covered when transport to an acute care Hospital is Medically Necessary and ground or water transportation is not appropriate.
- Non-emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) between facilities only when the transport is a result of any of the following:
  - Transfer from a Non-Network Hospital/Facility to a Network Hospital/Facility.
  - Transfer to a Hospital that provides a higher level of care than 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 Prior Authorization.

Autism Spectrum Disorders (ASD)
Covered Health Services under this section include coverage for the assessment, diagnosis, and treatment of Autism Spectrum Disorders. 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. Applied behavior analysis includes the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
- 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 applied behavioral analysis, Habilitative or Rehabilitative Services

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

Any treatment for Autism Spectrum Disorder must be deemed Medically Necessary and must have Prior Authorization by the Plan.

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

Blood & Blood Services, Hemophilia and Congenital Bleeding Disorders
Includes blood and the administration of blood products for the treatment of hemophilia and congenital bleeding disorders.

Chemotherapy Services – Outpatient
Covered Health Services under this section include chemical or biological antineoplastic agents administered as part of a doctor's visit, home care visit or at an outpatient facility for treatment of an illness.

Covered Health Services include medical education services that are provided on an outpatient basis by appropriately licensed or registered health care 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:

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

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

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

Chiropractic Care is limited to 30 visits per calendar year for rehabilitative chiropractic/osteopathic manipulation therapy, and 30 visits per calendar year for habilitative chiropractic/osteopathic manipulation therapy. Habilitative Services help You keep or improve skills and functioning for daily living includes services for people with disabilities in an inpatient or outpatient setting. Rehabilitative services must involve goals one can reach in a reasonable period of time.

Refer to the *Limitations/Exclusions* section to see services that are excluded from Chiropractic Care.

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

Cleft Lip and Cleft Palate Treatment
Covered Health Services under this section include the following services when provided by or under the direction of a Physician in connection with cleft lip, and/or cleft palate:

- Audiological services.
- Habilitative speech therapy.
- Medically Necessary orthodontic services.
- Oral and facial surgery, surgical management, and follow-up care by a plastic and/or oral surgeon.
- Otolaryngological services.
- Prosthetic devices such as obturators, speech appliances, and feeding appliances.
- Prosthodontic treatment.

Clinical Trials
Covered Health Services in 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 treating Physician or Covered Person provides medical and scientific information establishing that the Covered Person's participation in such trial would be appropriate.
- The Covered Person suffers from a condition that is life threatening.
- The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.
- The clinical trial or study is approved under the September 19, 2000, Medicare national coverage decision regarding clinical trials, as amended.
- 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.
- 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.

Coverage is subject to all terms and conditions of this Policy.

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.
- The cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration.
- Costs of services that (a) are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or (b) are performed specifically to meet the requirements of the Clinical Trial.
- Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing, and other expenses that the Covered Person or person accompanying the Covered Person may incur.
- An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the Covered Person.
- Costs for the management of research relating to the clinical trial or study.
- 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.
- After the clinical trial ends, coverage is not provided for non-FDA approved drugs that were

provided or made available to an enrollee during a covered clinical trial.

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

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

(A) Federally Funded Trials - The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  (i) National Institutes of Health.
  (ii) Centers for Disease Control and Prevention.
  (iii) Agency for Health Care Research and Quality.
  (iv) 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) Qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  (vii) Study or investigation has been conducted and approved through a system of peer review by one of the following:
    (I) Department of Veterans Affairs.
    (II) Department of Defense.
    (III) Department of Energy.

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

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

*"**Routine patient care cost**"* refers to items and services that are a Covered Health Service under this plan for a person with a similar condition who is not enrolled in a clinical trial. However, costs associated with the following are not Covered Health Services:

- 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.
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.
- 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.
- 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.

In the event a claim contains charges related to covered clinical trial services but those charges have not been or cannot be separated from costs related to non-covered services, benefits will not be provided.

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

Rehabilitation Outpatient Therapy services related to Congenital Defects and Birth Abnormalities 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. and are subject to the limitations described in the Outpatient Therapies section.

COVID-19 Testing, Treatment and Vaccinations
Testing, vaccinations, and treatment for services related to COVID-19 is covered under this plan. Services include:

- COVID-19 diagnostic testing. If you have symptoms, COVID-19 diagnostic testing and

associated office visits are covered at no cost to You. Testing for other purposes, such as return to work or checking one's own antibody levels, will not be covered. Please note, mail-order and over-the-counter COVID-19 diagnostic tests do not qualify for reimbursement.

- Early medication refills. We are authorizing early medication refills for members who might be impacted by the outbreak. To get your medication refilled early, contact your pharmacist and ask them to request approval. We are following national emergency declaration guidance for the allowance of early medication refills. If the national emergency declaration is lifted, this allowance will be lifted.

Telehealth Services (online and virtual care) obtained in connection with doctor-ordered COVID-19 testing and diagnosis are covered at no cost to You. Please visit our website at https://brighthealthcare.com/covid-19 for telehealth services information.

Dental Anesthesia
Covered Health Services under this section include medically necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to a covered person who is determined by a licensed dentist in consultation with the covered person's treating physician to require general anesthesia and admission to a hospital or outpatient surgery facility to effectively and safely provide dental care and (i) is under the age of five, or (ii) is severely disabled, or (iii) has a medical condition and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment. For purposes of this section, a determination of if are Medically Necessary shall include but not be limited to a consideration of whether the age, physical condition or mental condition of the covered person requires the utilization of general anesthesia and the admission to a hospital or outpatient surgery facility to safely provide the underlying dental care.

Dental Coverage for Medical Treatments
This Policy provides benefits for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants.

Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

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

- Outpatient diabetes care management including self-management training, education, and medical nutrition therapy services ordered by a Physician and provided by appropriately licensed or registered health care professionals.
- Medical eye examinations (dilated retinal examinations) for Covered Persons with diabetes.
- Preventive foot care for Covered Persons with diabetes, including treatment of corns, calluses, and care of toenails.
- Custom shoes for diabetics. Limited to one pair of custom shoes per calendar year as prescribed by a Physician in relation to the diagnosis of diabetes.
- Medical supplies and equipment to include insulin pumps, home blood glucose monitors and lancets, blood glucose test strips, syringes, and hypodermic needles. One Insulin pump every three years will be covered at 100% of the Allowed Amount and is not subject to the Annual Deductible, Copayment, or Coinsurance. Any supplies used in conjunction with the insulin pump will be subject to the *Durable Medical Equipment* provision.

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

Diagnostic Radiology and Imaging
Covered Health Services under this section include diagnostic and therapeutic imaging procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

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

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

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

Dialysis Services – Outpatient
Covered Health Services under this section include services for acute and chronic (end-state) renal disease, including hemodialysis, home intermittent peritoneal dialysis, home continuous cycling peritoneal dialysis, and home continuous ambulatory peritoneal dialysis, and dialysis treatments in an outpatient dialysis facility or a doctor's office.

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 health care 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.
- Home equipment, supplies and training for chronic (end-stage) renal disease.
- Benefits for other Physician services are described under the *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 is:

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

Equipment is only available when obtained from a Participating Provider, unless related to Emergency Health Services.

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. Maintenance and supplies needed for use of the equipment, such as a battery for a powered wheelchair are covered when Medically Necessary.

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 Allowed Amount to purchase the equipment. If You rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, You will be responsible for any cost difference between the piece You rent or purchase and the piece We have determined is the most cost-effective.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair, once every five years.
- A standard Hospital-type bed, once every five years.
- Oxygen and the rental of equipment to administer oxygen (including concentrators, ventilators, tubing, connectors, and masks).
- Cochlear implants
- Negative pressure wound therapy devices
- Traction equipment
- Walkers and crutches
- Delivery pumps for tube feedings.
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Nebulizers and Peak Flow Meters. Coverage under this plan includes the purchase of one nebulizer in a calendar year period, or one rental per episode, and the purchase of one 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 does not apply to damage due to misuse, malicious breakage, or gross neglect. Established guidelines by Medicare are followed for the lifetime of Durable Medical Equipment. Equipment is expected to last at least five years.
- Coverage is not available to replace lost items.

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

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

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

Early Intervention Services

Covered Health Services under this section include early intervention services for babies and children up to age 3 with developmental delays and disabilities. Such services may include speech therapy, physical therapy, and other types of services based on the needs of the child and family.

Services must be received from a qualified intervention services provider, and must be Medically Necessary.

The following services are excluded from coverage under this Benefit: :

- Assistive technology, unless otherwise covered under this Policy
- Non-emergency medical transportation
- Respite care; and

- Service coordination, other than Our care management services.

This Policy provides coverage for Medically Necessary early intervention services; such as speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents who are certified by the Department of Behavioral Health and Developmental Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention services for the population certified by the Department of Behavioral Health and Developmental Services shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure. This benefit is not subject to any dollar limits. No therapy visit maximum applies to Physical, occupational and speech therapy services provided as part of early intervention treatment.

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

Emergency Health Services
Covered Health Services under this section include the facility charge, supplies, and all professional services required to stabilize Your condition in an Emergency situation.

This includes:
- Professional Services including services rendered by the Emergency room Physicians, consulting Physicians, pathologists, radiologists, and anesthesiologists. Includes diagnostic x-ray, lab services, medical supplies, and advanced diagnostic imaging, such as MRIs and CAT scans to evaluate and treat a patient.
- Placement in an observation bed or a Crisis Stabilization Unit for the purpose of reducing the severity of Your Mental Health and/or Substance Use Disorder symptoms, when Medically Necessary (rather than being admitted to a Hospital for an Inpatient Stay)
- Admission for inpatient hospitalization only during the time that Your condition meets the definition of an Emergency. If You are admitted to a Non-Network facility through the emergency room, You, Your Physician or Hospital must notify Us within 24 hours, or as soon as reasonably possible.

Coverage shall be provided without any need for Prior Authorization and regardless of the final diagnosis rendered to the Covered Person. Visits to Out-of-Network emergency rooms for Emergency Health Services and supplies are covered at in Network levels and Network cost shares.

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

Refer to Prescription Drugs and Preventive Medications for information regarding Oral Contraception.

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

Gender Identity & Gender Transition Services
Covered Health Services under this plan include medical, behavioral health and prescription drug treatment related to gender dysphoria, gender identity, and gender transition.

Covered health Services will not include services considered to be cosmetic or not Medically Necessary.

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

Genetic Testing
Covered Health Services under this section include charges made for genetic testing that use 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.
- Services are in accordance with the A or B recommendations of the U.S. Preventive Services Task Force (USPSTF). Coverage may also be found under the *Preventive and Wellness Services* section of this Policy.

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

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

Coverage under this section includes charges for:
- The Facility
- Supplies and equipment
- Physician services

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

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

Skilled Care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:
- It 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.

- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care or domiciliary 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 care services include remote patient monitoring, visits by a health care professional (includes nurse, therapist or home health aide) for skilled care, diagnostic services, therapies (physical, occupational, speech, respiratory 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, and Durable Medical Equipment.

Home health services are limited to 100 visits per calendar year. This home health care visit limit applies to any combination of physical, occupational, speech therapy, or cardiac rehabilitation received in the home instead of any individual therapy limits. This home health care limit does not apply to home infusion therapy or home dialysis.

Hospice Care
Covered Health Services under this section include hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. No therapy visit maximum applies to any occupational, physical or speech therapy services received under this benefit.

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

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

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

Hospital and Free-Standing Facility Services
Covered Health Services under this section include services and supplies related to the care and treatment of a Sickness or Injury received during an Inpatient Hospital stay, Outpatient procedure or evaluation, or in an Emergency room. Coverage is available for:
- A Hospital room with two or more beds. If a private room is used, We will allow only up to the prevailing two-bed room rate, unless a private room is Medically Necessary.
- Care in Special Care Units such as Intensive Care, Cardiac Care, Neonatal Care, when Medically Necessary.
- Operating rooms, delivery rooms, and special treatment rooms.
- Supplies and services such as laboratory, cardiology, pathology, and radiology received while in the Hospital.
- Drugs, medicines, and oxygen provided during Your stay.
- Blood, blood plasma, blood derivatives and blood factors, blood transfusions including blood processing, and storage costs.

Hysterectomy Minimum Hospital Stay
Coverage is provided for laparoscopy-assisted vaginal hysterectomies and vaginal hysterectomies and includes Benefits for a minimum stay in the Hospital of not less than 23 hours for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy. A shorter stay is acceptable provided the attending Physician, in consultation with the Covered Person, determines that a shorter Hospital stay is appropriate.

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

Infusion Therapy Services – Outpatient
Covered Health Services under this section includes intravenous infusion therapy treatment received on an outpatient basis at a Hospital, Alternate Facility, or home care setting. This includes drug infusion therapy, blood products, and injectables that are not self-administered; total parenteral nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy as treatment of an Illness by chemical or biological antineoplastic agents. Services may include injections (intra-muscular, subcutaneous, continuous subcutaneous). Coverage includes infusion of special medical formulas for a person with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital, Alternate Facility, or home care setting by appropriately licensed or registered health care 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 the *Physician Fees for Surgical and Medical Services* provision of the *Benefits/Coverages (What is Covered)* section of this Policy. Nursing, durable medical equipment and drugs delivered and administered by a health care provider as part of a doctor's visit, home care visit, or at an outpatient facility.
- Includes drug infusion therapy, blood products, and injectables that are not self-administered;
- Total Parenteral Nutrition (TPN), Enteral nutrition therapy;
- Antibiotic therapy; Chemotherapy; Pain care.
- Covers infusion of special medical formulas as the primary source of nutrition for persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies.

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 or Skilled Nursing Facility and coverage is available for:

- Services, supplies, and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for anesthesiologists, consulting Physicians, pathologists, and radiologists. Benefits for other Physician services are described under the *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:
    - 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.
    - Ordered by a Physician.

- 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.
- 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.

Coverage is available only if both of the following are true:
- 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

Skilled Nursing coverage is limited to 100 days per stay.

Lab, X-Ray, and Diagnostic Services – Outpatient
Covered Health Services under this section include laboratory, pathology, x-ray, and radiology services (includes x-rays, mammograms, ultrasounds, or nuclear medicine) performed for diagnostic purposes received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office.

Coverage under this section includes charges for:
- The Facility
- Supplies and equipment
- Physician services

Diagnostic imaging services includes EKGs, EEG, and echocardiograms. Hearing and vision test for a medical condition or injury are also covered. Advance diagnostic imaging coverage including MRA, MRI, CTA, PET scans, CT scan, PET/CT fusion scans, SPECT scans, QCT scan, densitometry, diagnostic CT colonography, and nuclear cardiology. Diagnostic sleep testing is covered.

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

Lymphedema
Charges for the diagnosis, evaluation and treatment of lymphedema and are paid on the same basis as any other medical condition. Coverage will include benefits for equipment, supplies, complex decongestive therapy, gradient compression garments, which require a prescription and are custom-fit for the Insured, self-management training and education, if the treatment is determined to be Medically Necessary and is provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice.

Medical Supplies and Disposable Items
Covered Health Services under this section include disposable medical supplies suitable for use in the home.

Some covered items may include:
- Syringes, needles, dressing, splints, etc.
- Burn garments
- Ostomy Supplies
  - Irrigation sleeves, bags, catheters
  - Pouches, face plates, belts
  - Skin barriers
- Supplies related to insulin pumps
- Tubing and connectors for delivery pumps

We may limit the quantities of certain supplies to an amount considered to be reasonable for a 30-

day period. When quantities exceed what We consider reasonable for a given time frame, there must be an explanation of the Medically Necessary reason 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 Use Disorder Services – Inpatient, Outpatient, and Intermediate Care

Covered Health Services under this section include treatment for Mental Health Disorders and Substance Use Disorder services received on an Inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, or services received on an outpatient basis in a Provider's office or at an Alternate Facility.

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

Mental Health and Substance Use Disorder Services

Inpatient Services

Covered Health Services under this section include Mental Health and Substance Use Disorder Services received on an inpatient basis in a Hospital and coverage for inpatient professional charges in any Hospital or facility required by state law, , including:

- Crisis intervention
- Diagnosis and psychological testing
- Medication management
- Mental health, Substance Use Disorder, and chemical dependency evaluations and assessment
- Detoxification
- Referral services
- Individual, family, and group psychotherapy, including intensive therapy and counseling for family members to assist with the patient's diagnosis and treatment, convulsive therapy and rehabilitation treatment.
- Treatment planning

Intermediate Care

Intermediate Care services may include:

- Residential treatment, which includes coverage for inpatient services for Substance Use Disorder, eating disorders and the like and must be provided in a Hospital or treatment facility that is licensed to provide a continuous, structured program of treatment and rehabilitation, including 24-hour per day nursing care. Individual and intensive treatment includes observation and assessment by a psychiatrist at least weekly and rehabilitation, therapy, education and recreational or social activities.
- Crisis stabilization.
- Partial hospitalization.
- Intensive outpatient program.

Detoxification

Covered Health Services include medical management of potentially dangerous or life-threatening withdrawal symptoms on an inpatient or intermediate care basis. Detoxification may be considered an Emergency and covered at a Non-Network Facility in limited situations when it is determined to be Medically Necessary.

Bright HealthCare maintains compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) as well as any additional state parity requirements. Bright HealthCare will not impose more restrictive financial requirements or treatment limitations to Mental Health or Substance Use Disorder benefits than those on medical/surgical benefits.

Partial Hospitalization

Covered health services include an approved day or evening treatment program that includes major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional or nervous disorders and alcohol or other drug dependence who

require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individual or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatient.

Outpatient Services
Covered outpatient services for treatment of psychiatric conditions within a Provider's office or outpatient Facility may include:

- Physician's charges
- Crisis intervention
- Diagnosis and psychological testing
- Medication management
- Mental Health, Substance Use Disorder, and chemical dependency evaluations and assessment
- Referral services
- Individual, family, and group psychotherapy, including intensive therapy
- Treatment planning

Oral Surgery
Important Note: Although this plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.
Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Maxillary or mandibular frenectomy when not related to a dental procedure.
- Alveolectomy when related to tooth extraction.
- Orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or bone and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the "Dental Care" section.
- Surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Orthotics
This Policy provides benefits for certain types of orthotics (braces, boots, Splints). Covered Services include the initial purchase, fitting, adjustments and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Palliative Care
We cover Palliative Care to provide relief from pain and other symptoms of a serious illness, regardless of the diagnosis or stage of disease.

Pediatric Dental Care
Coverage for this benefit is limited to Enrolled Dependent Children under 19 years of age. Coverage ends on the last day of the month in which the dependent child turns age 19.

Services are covered when received from a Network Provider. There are no Benefits for services received from a Non-Network Provider. You may find a Network Provider on Our website at https://client.libertydentalplan.com/BrightHealthExchange/FindADentist.

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-month intervals.
- Sealants on unrestored permanent molar teeth of one per lifetime per tooth.
- Topical fluoride application twice in a 6-month period
- Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

The number and frequency of each of these services is limited. Refer to the *Pediatric Dental – Limitations* and *Pediatric Dental – Exclusions* sections for specific covered and excluded services.

Basic Dental Care

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

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

The number and frequency of each of these services is limited. Refer to the *Pediatric Dental – Limitations* and *Pediatric Dental – Exclusions* sections for specific covered and excluded services.

Major Dental Care:

Endodontics

This plan covers routine endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required, endodontic therapy of previous root canal, apicoectomy riling.

The number and frequency of each of these services is limited. Refer to the *Pediatric Dental – Limitations* and *Pediatric Dental – Exclusions* sections for specific covered and excluded services.

Periodontics

This plan covers non-surgical periodontal services, including gingivectomy, scaling and root planning, full mouth debridement, osseous surgery, provision splinting and grafting. We will cover periodontal surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects. This plan will also cover periodontal services in anticipation of or leading to orthodontics that are otherwise covered under this Policy.

The number and frequency of each of these services is limited. Refer to the *Pediatric Dental – Limitations* and *Pediatric Dental – Exclusions* sections for specific covered and excluded services.

Prosthodontics

This plan covers the following prosthodontic services:

- Additional services including insertion of identification slips, repairs, relines and rebases, and treatment of cleft palate.
- Interim prosthesis for enrolled children
- Removable complete or partial dentures, including six months of follow-up care.
- Single crowns, one 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 per the following:

- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

- For cleft palate stabilization.
- 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.

The number and frequency of each of these services is limited. Refer to the *Pediatric Dental – Limitations* and *Pediatric Dental – Exclusions* sections for specific covered and excluded services.

Oral Surgery
This plan covers non-routine oral surgery, such as:
- Mobilization of erupted or mal-positioned tooth to aid eruption.
- Partial and complete bony extractions.
- Placement of device to facilitate eruption of an impacted tooth.
- Surgical access of an unerupted tooth.
- Tooth transplantation.
- Biopsy
- Alveoloplasty of one per quadrant per lifetime.
- Removal of cysts, tumors and growths
- Drainage of abscesses
- Occlusal orthotic device for TMJ
- Frenulectomry/Frenuloplasty of one per lifetime

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

The number and frequency of each of these services is limited. Refer to the *Pediatric Dental – Limitations* and *Pediatric Dental – Exclusions* sections for specific covered and excluded services.

Orthodontics
This plan covers orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as:
- Ankylosis of the temporomandibular joint.
- Cleft palate and cleft lip.
- Extreme mandibular prognathism.
- Maxillary/mandibular micrognathia (underdeveloped upper or lower jaw).
- Other significant skeletal dysplasia.
- Severe asymmetry (craniofacial anomalies).

Procedures include but are not limited to:
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted).
- Interceptive orthodontic treatment.
- Orthodontic retention (removal of appliances, construction, and placement of retainers).
- Placement of component parts (e.g., brackets, bands).
- Rapid Palatal Expansion (RPE).
- Removable appliance therapy, including appliances for thumb sucking and tongue thrusting limited once per lifetime.

Orthodontic treatment is covered only when Medically Necessary as evidenced by a handicapping malocclusion and when 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 is limited. Refer to the *Pediatric Dental – Limitations* and *Pediatric Dental – Exclusions* sections for specific covered and excluded services.

Pediatric Dental Anesthesia
Covered Health Services under this section include general anesthesia when rendered in a Hospital, outpatient surgical Facility, or other licensed Facility, and associated Hospital and Facility

charges for dental when the person has a physical, mental, or medically compromising condition, has dental needs that would make local anesthesia ineffective because of anatomic variations, infection or allergy, or is extremely uncooperative, unmanageable, anxious, or uncommunicative. Services for Pediatric Dental Anesthesia will apply the medical deductible, copay and/or coinsurance amount appropriate for the type of facility in which the services are administered.

Pediatric Vision Care
Coverage for this benefit is limited to Enrolled Dependent Children under 19 years of age. Coverage ends on the last day of the month in which the dependent child turns age 19.

Services are covered when received from a Network Provider. There are no Benefits for services received from a Non-Network Provider. You may find a Network Provider on Our website at https://eyedoclocator.eyemedvisioncare.com/brighthealth/en.

Covered Health Services under this section include routine vision examinations, including refractive examinations to determine the need for vision correction when they are provided by a Network Provider. One vision examination is covered each calendar year with no cost share for Preventive Care services.

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

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

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

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services*.

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

Physician’s Services for Sickness and Injury
Covered Health Services under this section include services provided by a Physician's for the diagnosis and treatment of a Sickness or Injury, including remote patient monitoring services and office surgeries. Coverage is provided under this section regardless of whether the Physician's office is freestanding, provided as a home visit, located in a clinic, located in a Hospital, or provided as Telemedicine, including online visits by a webcam, or voice. This includes Retail Health Clinics (walk-ins) for routine care and common illnesses.

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

- Education is required for a disease in which patient self-management is an important component of treatment

- There exists a knowledge deficit regarding the disease, which requires the intervention of a trained health professional

Covered Health Services under this section include allergy testing and treatment, allergy shots and allergy serum.

Covered Health Services for Preventive Care provided in a Physician's office are described in the *Preventive and Wellness Services* section.

Clinic Fees
For Physician's Office Services received at an Outpatient Clinic that is owned by a Hospital, a clinic fee may be billed by the Provider. This fee is not covered as part of the Office Visit. Your Deductible and Coinsurance will apply to Clinic Fees and charges You pay will count towards Your Out-of-Pocket Maximum.

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

Post-Stabilization Services
Covered Health Services under this policy include services provided following an Emergency situation when Your condition is stabilized. If You received Emergency care at a Non-Network Facility:

- We may transfer You to the nearest appropriate Network or Participating facility for Medical Necessary post-stabilization care if You are able to use non-medical transportation or non-emergency medical transportation.

If You are admitted to a Network facility from the emergency room, Your emergency room cost-share will be waived and your Inpatient Hospitalization cost-share will apply.

Pregnancy – Maternity Services
Covered Health Services in this section for the Subscriber and covered Dependents who become pregnant include Benefits for Pregnancy and all maternity-related medical services for pregnancy testing, prenatal care, postnatal care, delivery, and any related complications of Pregnancy. This includes charges for a certified nurse midwife. Prenatal and postnatal care includes maternity care for related check-ups and services for pregnancy and complications of Pregnancy for which hospitalization is necessary. Postnatal services for newborns includes behavioral assessments and measurements; screenings for blood pressure, hearing, hemoglobinopathies, hypothyroidism, PKU, and Gonorrhea prophylactic medication. Covered services also include dental services and dental appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. Benefits include fetal screenings for genetic and/or chromosomal status of the fetus 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.

Other Covered Health Services include anatomical, biochemical or biophysical tests to better define the likelihood of genetic and/or chromosomal anomalies, screening for pregnant women for anemia, gestational diabetes, Hepatitis B, Rh incompatibility, and urinary tract or other infection, folic acid supplements and expanded tobacco intervention and counseling for pregnant users. Covered Health Services also include related tests and treatment, and breast feeding supplies including one breast pump per pregnancy.

Note: There is no member cost share for required Preventive Services.

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

Note: If 48- or 96-hours following delivery falls after 8:00 p.m., coverage shall continue until 8:00 a.m. the following morning.

Coverage will be provided for an inter-Hospital transfer of a (i) newborn infant experiencing a life-threatening Emergency Condition or (ii) the hospitalized mother of such newborn infant to accompany the infant regardless of Prior Authorization.

Coverage is provided for Hospital services for routine nursery care during the mother's normal Hospital stay, other covered services include delivery and well-baby care in the Hospital or at a stand-alone birthing center for room, care, anesthesia services, and newborn services including a newborn pediatric visit and newborn Hearing Screening.

Benefits are also provided for inpatient care and a home visit or visits which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

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

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:

- Annual Deductibles, Copayments, Coinsurances, Days' Supply Limits, and other Quantity or Supply Limits.
- Eligibility at the time of service.
- Pharmacy filling Your prescription.
- Tier of the medication on Our Formulary.

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 Us to consider the prescription for reimbursement under Your Benefits. You will always be responsible for any Deductibles, Copayments, Coinsurance, or other limits under this Benefit. Only pharmacies that participate in Our pharmacy network are able to fill Your prescriptions under this Benefit.

Pharmacy Network
We recommend you use a Network Pharmacy to receive Benefits under this Policy. To find a Network Pharmacy, visit Our website at www.brighthealthcare.com or call the Customer Service number listed on Your ID Card.

If You go to an non-Network Pharmacy for any covered pharmacy benefit, Bright Health will not charge You more than your copayment for a Network Pharmacy if the non-Network Pharmacy submits a reimbursement agreement by electronic or telephonic transmission.

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, We recommend You 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. Call Customer Service at the telephone number on Your ID Card to find out which Providers are included 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.

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 and any additional requirements 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 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. You will receive, not less than 30 days' prior written notice of a modification to a formulary that results in the movement of a prescription drug to a tier with higher cost-sharing requirements.

Additionally, the status of a medication may change from Brand Name to Generic. Brand Name or Generic product status may impact Your costs and coverage under this Benefit.

A Medically Necessary non-formulary Prescription Drug may be obtained with no additional cost-share through the Exception process. An exception may also be given for a non-formulary drug to be obtain without additional cost-sharing when the Enrollee has been receiving the specific non-formulary Prescription Drug for at least six months previous to the development or revision of the Formulary and the prescribing Physician has determined that the Formulary drug is an inappropriate therapy. Please see the *Exception* section below for more information.

The complete, current drug Formulary is available to participating Providers, any non-participating Providers, or for You at Our website www.brighthealthcare.com or contact the Customer Service at the number listed on Your ID Card to request a copy.

Medical versus Pharmacy Benefits
The drug formulary applies to your pharmacy benefits only. Medications covered under pharmacy benefits typically include self-administered drugs that are picked up at a Retail Pharmacy or delivered to the home. Drugs administered at a physician's office, infusion clinic, or inpatient facility

are typically covered under your medical benefit and subject to the applicable cost-share amount.

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.

Many prescriptions will be eligible as written by the Provider, up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size, or based on other Quantity or Supply Limits.

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

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

Limitation on Selection of Pharmacies

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

Prior Authorization

Some Prescription Drug Products may require Prior 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. Prior Authorization is used to verify that certain requirements have been met before coverage of a specific type of prescription is dispensed. Without Prior Authorization approval, Your Prescription Drug Product may not be covered. Refer to the Formulary at www.brighthealthcare.com to find out which medications require Prior Authorization.

Prior authorization for brand drugs may be approved because less costly equivalent alternatives are not available. If a lower cost equivalent brand, generic, or biosimilar becomes available as a preferred drug, only the preferred drug will be covered.

For certain physician administered medications, covered under your medical benefit, We may require Prior authorization for the medication and also the site where the drug will be provided.

Step Therapy

Step Therapy encourages You to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require You to try Drug A first. If Drug A does not work for You, the plan will then cover Drug B. The requirement to try a different drug first is call "Step Therapy." Refer to the Formulary at www.brighthealthcare.com to find out which medications require Step Therapy.

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

You are not required to undergo Step Therapy or receive Prior Authorization before a pharmacist may prescribe and dispense an HIV infection prevention drug.

If You have stage four advanced metastatic cancer, You are not required to undergo Step Therapy

for a covered medication that has been approved by the U.S. Food and Drug Administration, or other recognized body, for the treatment of stage four advanced metastatic cancer.

Exceptions

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

If the plan does not cover Your medication or has restrictions or limits on Your medication that will not work for You, You can do one of the following:

- Ask Your health care Provider if there is another covered medication that will work for You.

Your health care Provider can ask the plan to make an "exception" to cover a medication or to remove medication restrictions or limits.

Examples of exceptions:

- 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
- Medication prescribed by Your qualified health care Provider is more effective for You than the medication that is normally covered.

Exceptions for brand drugs may be approved because less costly equivalent alternatives are not available. If a lower cost equivalent brand, generic, or biosimilar becomes available as a preferred drug, only the preferred drug will be covered.

New drugs to market that have not been reviewed by our Pharmacy and Therapeutics Committee are excluded from the formulary exceptions process, and coverage, until reviewed for safety, efficacy, and uniqueness by our Pharmacy and Therapeutics Committee.

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 call the Pharmacy Customer Services number on Your ID Card.

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

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

For additional information about the prescription drug exception process for drugs not included on Your plan's Formulary, contact the Customer Service number on Your ID Card.

Off-Label and Cancer Medications

Covered Health Services under this section include the Off-Label Use of a medication for the treatment of cancer and for Medically Necessary services for administration of the drugs under this provision.

Benefits will not be denied for any drug approved by the USFDA to treat (i) cancer because the drug has not been approved by the USFDA for that specific type of cancer for which the drug has been prescribed, or (ii) a covered indication if the drug has been approved by the USFDA for at least one indication, if the drug is recognized in standard reference compendia as safe and effective

or in substantially accepted peer-reviewed medical literature for treatment of that specific type of cancer, or that covered indication, respectively.

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 compendia: (1) National Comprehensive Cancer Network (NCCN), (2) American Hospital Formulary Service (AHFS) DrugDex, (3) LexiComp, or (4) Clinical Pharmacology.

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

Oral Anticancer Medication

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

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

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

Drug Tiers

Coverage will be paid according to the medication classification (e.g. 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 and in accordance with state Regulations. Your cost share amounts for each drug tier can be found in Your Schedule of Benefits. You can determine the tier of Your medication on the Plan Formulary.

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

Tier 1: Preventive Medications with no member cost share under the Affordable Care Act
Tier 2: Preferred Generic Medications
Tier 3: Non-Preferred Generic Medications; Preferred Brand Medications
Tier 4: Non-Preferred Generic Medications; Non-Preferred Brand Medications
Tier 5: Specialty Medications and Formulary Exceptions
Tier 6: $0 Generic Drugs. This tier is designated for a specific list of generic drugs for certain plans. Not all generic drugs will fall under this tier.

Some Specialty Medications are available in other tiers. Review Our Formulary at www.brighthealthcare.com to determine what tier Your specialty medication falls in. Refer to Your Schedule of Benefits for Your costs related to these drug tiers.

Covered Medications and Products

Covered products are subject to Deductibles, Copayments and/or Coinsurance, Formulary status, Brand Name or Generic status, Specialty Prescription status, and pharmacy network status, as well as other Days' Supply Limits, or Quantity or Supply Limits defined in Our Formulary.

- Coverage is limited to prescription products, prescribed by a legal prescriber. Prescription Medications are labeled as "Caution: Federal Law Prohibits Dispensing without a Prescription," "Rx Only," and/or where Virginia recognizes such products as requiring a

prescription or mandates coverage as such.

- Insulin is covered as a prescription product, along with syringes, and items required for monitoring diabetes treatment and testing strips, ketone urine test strips, lancets and related devices, pen delivery systems for insulin administration, insulin syringes, visual aids to support the visually impaired with the proper dosing of insulin (except eyewear), Prescription Medications for treatment of diabetes (oral medications), and glucagon. For most plans, Your cost for a 30-day supply of insulin will not exceed $50. If You are enrolled in a Catastrophic plan, Your cost may exceed this amount.
- 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 all ingredients in the compounded medication are covered on our formulary and dispensed by a Network Pharmacy. Compounded medications must 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 as prescribed by a doctor and medically necessary, and subject to the same Deductibles, Copayments, and Network Providers as other prescription products, when used to treat PKU.
- Medically necessary formula and enteral nutrition products and any medical equipment, supplies and services required to administer, for the treatment of inherited metabolic disorder and for which the covered person's Physician has issued a written prescription.
- Specialty Pharmaceutical medications, as defined by the plan when dispensed by Our Specialty Pharmacy Network Supplier.
- Contraceptive medications, devices, and various other products are covered for use as birth control.
- Immunizations administered at a Network Pharmacy.
- Flu shots and their administration.
- Medications prescribed to treat Emergency medical conditions while traveling outside the United States.
- Prescription drugs (or inpatient or IV therapy drugs) used in the treatment of cancer pain on the basis that the dosage exceeds the recommended dosage of the pain relieving agent, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain

We may limit the quantities of certain supplies to an amount considered to be reasonable for a 30-day period. When quantities exceed what We consider reasonable for a given timeframe, there must be an explanation of the Medically Necessary reason for the quantities. If this information is not provided to Us, there may be a delay in processing the claim or the claim may be denied.

Prescription Eye Drop Refills

Prescription eye drop refills 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 21 days for a 30-day supply of eye drops, 42 days for a 60-day supply of eye drops, or 63 days for a 90-day supply of eye drops from the last date that the prescription was filled. One additional bottle of prescription eye drops will be allowed if a bottle is requested by the Covered Person or Provider at the time the original prescription is filled and the original prescription states that one additional bottle is needed by the insured for use in a day care center, school, or adult day program. The additional bottle is limited to one bottle every three months.

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

Synchronization of Prescription Refills

When agreed upon by You, the prescribing Physician, or 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 policy.

- The medications are used for treatment and management of illnesses, and the medications are subject to refills.
- The medications meet all Prior 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.

Split Fill Program
You may only be able to receive a partial fill (14-15 days) of certain medications for up to the first 90 days of treatment. This is to make sure the medication is working for You. Your cost share or copay will be adjusted to reflect the days' supply dispensed.

Opioid Dependence
Once within a 12-month period, We will provide coverage for a five-day supply of an FDA-approved medication without Prior Authorization when the medication is being issued for the treatment of opioid dependence. Subsequent requests for the medication may require Prior Authorization.

What You Must Pay
You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table for Generics, and for Brand Name medications, non-Formulary Drugs, and specialty prescription medications once the deductible is met.

When calculating Your contribution to any Out-Of-Pocket Maximum, Deductible, Copayment, Coinsurance, or other applicable cost sharing requirement, We will include any amount paid by You for a prescription drug that is either:
- Without a Generic equivalent, or
- With a Generic equivalent where You have obtained access to the prescription drug through any of the following:
- Prior Authorization
- Step therapy protocol
- Our exceptions and appeals process.

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

Drug Manufacturer Coupons
Drug manufacturer or third-party copay assistant programs may offer coupons, rebates, or other copay assistance to You which could lower Your out-of-pocket costs. The value of any manufacturer or third party copay or cost share assistance will not apply to Your annual deductible annual maximum out-of-pocket limits.

Preventive Medications
Covered Health Services under this section include preventive medications in accordance with the A or B recommendations of the USPSTF:
- Aspirin.
- Bowel preparation for colonoscopy screening Generic and Brand Name prescription and OTC preparations, two per calendar year.
- Breast cancer preventive medications, such as tamoxifen, raloxifene, or aromatase inhibitors, for women 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 six to 12 months who are at risk for iron deficiency anemia.
- Low to moderate dose statin preventive medication for adults age 40 to 75 with no history of cardiovascular disease for the prevention of cardiovascular disease events and mortality.
- Oral fluoride chemoprevention supplementation starting at age six 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 USPSTF or as required by state or federal law. For a complete list of Preventive Care services, visit the USPSTF website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.

Preventive and Wellness Services

Covered Health Services under this section include A & B Preventive Health Care services recommended by the U.S. Preventive Task Force (USPSTF). You can find a list of these services at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.

Preventive services for adults include screening for abdominal aortic aneurysm, alcohol misuse, colorectal cancer, high blood pressure, Type 2 Diabetes, cholesterol, depression, Hepatitis B and C, HIV, lung cancer, obesity, syphilis, and tobacco use. Also includes counseling for alcohol misuse, nutrition, obesity, sexually transmitted infection prevention, and smoking and tobacco cessation products, including nicotine patches and gum when obtained with a prescription. Covers aspirin use to prevent cardiovascular disease. Routine prostate specific antigen testing (PSA) and digital rectal exam will be covered in accordance with the American Cancer Society guidelines.

Additional preventive and wellness services covered under this Plan are:

- Prenatal fetal screenings for pregnant women for genetic and/or chromosomal status of the fetus. Also includes anatomical, biochemical, or biophysical tests to define the likelihood of genetic and/or chromosomal anomalies. Covers screening for anemia, gestational diabetes, Hepatitis B, Rh Incompatibility, and urinary and other infections. Also covers folic acid supplements and expanded tobacco intervention and counseling.
- Post-natal diabetes mellitus screening for women with a history of gestational diabetes mellitus who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes. Initial testing should occur within the first year postpartum and can be conducted as early as 4-6 weeks postpartum. Women with a negative initial post-partum screening test result should be rescreened at least every three years for a minimum of ten years after pregnancy. For women with a positive postpartum screening test result, testing to confirm the diagnosis of diabetes is indicated regardless of the initial test (e.g. oral glucose tolerance test, fasting plasma glucose, or hemoglobin A1c). Repeat testing is indicated in women who were screened with hemoglobin A1c in the first six months postpartum regardless of the result.
- Includes well woman visits; Screenings for BRCA risk assessment and genetic testing, breast cancer mammography, cervical cancer, domestic and interpersonal violence, HPV, sexually transmitted infections (STIs) and HIV, and osteoporosis; Counseling for breast cancer genetic testing (BRCA), breast cancer chemoprevention, domestic and interpersonal violence, and STIs.
- Preventive Service for infants, children and adolescents, including assessment for alcohol and drug use, behavioral, oral health risk; medical history; BMI measurements; screenings for autism (18 to 24 months old); blood pressure; cervical dysplasia; depression; developmental dyslipidemia; hematocrit or hemoglobin; Hepatitis B; HIV; lead; obesity; sexually transmitted disease (STIs); tuberculin and vision. Also includes counseling for obesity and STI and fluoride chemoprevention supplements.

- Infant hearing screenings and all necessary audiological examinations for Newborn children using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such coverage shall include benefits for any follow-up audiological examinations as recommended by a physician or Audiologist and performed by a licensed Audiologist to confirm the existence or absence of hearing loss. Advanced Imaging services, X-rays, Laboratory Procedures, and Diagnostic Imaging may require Prior Authorization.
- Pediatric Preventive Care as adopted by the American Academy of Pediatrics or as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention including periodic health evaluations, laboratory services.,
- Immunizations for children, adolescents and adults as recommended by the Advisory Committee on Immunization Practices for the Centers of Disease Control and Prevention.
- Prescribed contraceptive drugs or devices including oral, implanted and injectable contraceptive prescription drugs. This includes all eighteen (18) FDA approved contraceptive methods and sterilization treatments for women and related counseling.

When these services are received from a Network Provider, they are covered at no cost to You.

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

Private Duty Nursing
Covered Health Services under this section include Medically Necessary nursing care that is provided to a patient on a one-to-one basis by licensed registered nurse (RN) or licensed practical nurse (LPN) in a home setting.

Private Duty Nursing Services provided in-home are limited to 16 hours per benefit period.

Prosthetic Devices
Covered Health Services under this section include external prosthetic devices that replace in whole or in part a limb, specifically an arm, leg, foot, or any portion of an arm, hand, leg or foot, and components Medically Necessary for daily living, colostomy and other related ostomy supplies, composite facial prosthesis, limited to:

- Prosthetics will be covered in accordance with recommended guidelines and criteria.
- Bionic, myoelectric, microprocessor-controlled, and computerized Prosthetics are covered in accordance with Medicare guidelines and criteria.
- Artificial face, eyes, ears, and noses.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.
- Wigs for Covered Persons undergoing treatment for cancer or other conditions treated by chemotherapy or radiation. Limited to one (1) wig per calendar year.

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 fitting, component materials and equipment needed to ensure comfort and functioning of the device, adjustments, repairs and replacement, except that:

- There are no Benefits for repair and replacement due to neglect, misuse or abuse

Implanted Medical Devices

Implanted medical devices must be Prior Authorized by Us and must be ordered by a 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 health care 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 and Physician services for anesthesiologists, pathologists, and radiologists. Includes coverage for the treatment of an illness by x-ray, radium, or radioactive isotopes. And includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration, and treatment planning. Proton radiation therapy shall not be held to a higher standard of clinical evidence than other types of radiation therapy for cancer treatment. Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services provision of the *Benefits/Coverages (What is Covered)* section of this Policy.

Rehabilitative and Habilitative Services – Outpatient Therapy

Covered Health Services under this section include short-term outpatient Rehabilitative Services (where attainable goals are set for a reasonable amount of time) and Habilitative Services. Visits are limited to 30 visits each for Rehabilitative Services and Habilitative Services for physical and occupational therapy combined. Services include:

- Cardiac Rehabilitation, including medical evaluation, training and supervised exercise and psychosocial support following a cardiac event. Services will not be provided for home programs (other than home health care services) on-going conditioning and maintenance care.
- Occupational therapy to restore activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, bathing and job-related activities.
- Physical therapy, provided by a licensed therapist to ease pain, restore health and avoid disability after an illness, injury or loss of arm or a leg. Including hydrotherapy, heat, physical agents, bio-mechanical neuro-physiological principles and devices. Includes treatment of lymphedema.
- Pulmonary Rehabilitation, including outpatient short-term respiratory care following an injury or illness.
- Respiratory therapy, including introduction into the lungs of dry or moist gases, non-pressurized inhalation; intermittent positive pressure breathing treatment, air or oxygen , with or without nebulized medication; CPAP; CNP; chest percussion; therapeutic use of medical gases or aerosol drugs, and equipment such as resuscitators, oxygen tents and incentive spirometers; broncho pulmonary drainage and breathing exercises.
- Speech therapy services to identify, assess and treat speech, language and swallowing disorders in Children and adults. Therapy will treat communication or swallowing difficulties to correct speech impairment. Also includes therapy to keep, learn or improve skills needed for daily living, such as therapy for a child who is not walking or talking at the expected age. Speech therapy and speech-language pathology limited to 30 visits each for Rehabilitative and Habilitative Services.

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 to improve function and/or to create a normal appearance, to the extent possible.

Cosmetic Procedures are excluded from coverage. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury or Sickness 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 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

We will cover Inpatient Hospital care for a minimum of 48 hours following a radical mastectomy and a minimum of 24 hours following a total or partial mastectomy lymph node dissection.

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)* section for details. If You would like more information on WHCRA Benefits, call Us at the number listed in the *Contact Us* section of this Policy or on the back of Your ID Card.

Skilled Nursing Facility

Covered Health Services under this section include charges incurred while confined in a Skilled Nursing Facility. Coverage is available for:

- Physician and non-Physician services including, but not limited to, charges for anesthesiologists, consulting Physicians, pathologists, and radiologists.
- Medically Necessary supplies.
- Room and board in a Semi-private Room (a room with two or more beds) or a Medically Necessary private room.
- Skilled convalescent care
- Drugs and biologicals
- 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.

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 100 days per stay.

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. This also includes devices and supplies for the treatment of Sleep Treatment, such as APAP, CPAP, BPAP, and oral devices for sleep treatment.

Sterilization Services
Covered Health Services include sterilization services and services to reverse non-elective sterilization that was the result of an illness or Injury. Reversal of elective sterilizations is not covered. Sterilization procedures for women are considered part of the *Preventive Care Services* provision, and therefore, no cost sharing is required.

Surgery – Inpatient and Outpatient
Covered Health Services under this section include surgery and related services for a Sickness, Injury, or condition that are received in a doctor's office, inpatient or outpatient basis at a Hospital or Alternate Facility, include pre-operative and post-operative care. For the purposes of this Benefit, congenital heart disease is considered a Sickness.

Benefits under this section include:
- Coverage for blood and blood products.
- Procedures to correct congenital abnormalities that cause functional impairment
- Newborn congenital abnormalities, or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery.
- Invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
- Treatment of fractures and dislocation.
- Pre-operative and post- operative care.
- Hypodermic needles, syringes, surgical dressings, splints, etc.
- Services rendered by an anesthesiologist.

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 which is a result of an accident, trauma, craniomandibular disorders, a congenital or developmental defect or a pathology.

Covered Health Services include removable appliances (except as specifically excluded), diagnosis, related medical care and surgical treatment of TMJ that is recognized by the medical or dental profession as effective and appropriate for TMJ, including intra-oral splints that stabilize the jaw joint.

Tobacco Use Counseling and Interventions
We have resources available to help You stop using tobacco. The Centers for Disease Control has tips on how You can quit smoking at www.cdc.gov/tobacco/campaign/tips/quit-smoking.

Your Primary Care Physician can assist You with cessation aids, if necessary. Our Formulary includes the following tobacco cessation aids:
- Buproprion
- Chantix .5mg

- Chantix 1mg
- Chantix starter kit
- Nicotine gum
- Nicotine lozenges
- Nicotine patches

Transplantation Services
Covered Health Services under this section include organ, tissue and stem cell/bone marrow 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. All transplants must be performed at a plan-designated Centers of Excellence Facility or transplant center. This plan also covers necessary acquisition procedures, mobilization, harvest and storage, and preparatory myeloablative therapy, reduced intensity preparatory chemotherapy, radiation therapy, infusions, or a combination of these therapies.

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

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under this Policy. When the donor is a non-covered member and the person receiving the organ is covered, benefits are limited to benefits not available to the donor from any other source.

Travel Expenses
Covered Services under this Benefit include reimbursement for reasonable and necessary transportation and lodging costs for the recipient and companion or two companions if recipient is a minor to receive care from a designated Center of Excellence Facility.

Travel expenses are reimbursable if We direct You for treatment a Facility not within Our Service Area because treatment is not available Network.

Travel expenses are reimbursable for reasonable and necessary transportation and lodging costs for the donor, are covered when the recipient and donor are covered by the same insurance carrier.

Travel reimbursement amounts are based on the Federal Continental United States (CONUS) rate for the city in which services are received.

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

If you need assistance with reimbursement for travel expenses, contact Customer Service at (844) 926-4524.

Urgent Care Center Services
Covered Health Services under this section include services received at an Urgent Care Center for urgent but non-emergent conditions 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 earache, 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.

Vision Correction after Surgery or Accident
Covered Health Services under this section include prescription glasses or contact lenses required as a result of surgery or for treatment of accidental Injury, including the cost of materials and fitting, exams, and replacement of eyeglasses or contact lenses if related to the surgery or Injury.

Eyeglass or contact lens purchase and fitting are covered under this Benefit if:

- Prescribed to replace the human lens lost due to surgery or Injury.
- “Pinhole” glasses are prescribed after surgery for a detached retina, or
- Lenses are prescribed instead of surgery due to:
  - Contact lenses used for treatment of infantile glaucoma.
  - Corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.
  - Corneal or scleral lenses prescribed in connection with keratoconus.
  - Scleral lenses prescribed to retain moisture when normal tearing is not possible or is inadequate.

Vision Services
Physician Services to treat an injury or disease of the eye(s)., including aphakia, diabetic retinopathy, and treatment cataracts including initial glasses or contact lenses following cataract surgery are covered under this Plan.

Section 7 – 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 e.g., Alternative Treatments below). The headings group services, treatments, items, or supplies that are in similar categories. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit, or expand an exclusion. All exclusions in this section apply to You.

Benefit Limitations
When Benefits are limited within any of the Covered Health Service categories described in *Benefits/Coverages (What is Covered)* section of this Policy, those limits are stated in the corresponding category in the Schedule of Benefits section. Limits may also apply to some Covered Health Services that are under more than one Covered Health Service category. When this occurs, those limits are also stated in the Schedule of Benefits under the heading *Benefit Limits*. 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 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.

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.

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

Alternative Treatments
This includes, but is not limited to:

- Acupressure
- Acupuncture
- Aromatherapy
- Auditory Integration Therapy (AIT)
- Bio-Energetic Synchronization Technique (BEST)
- Colonic irrigation
- Contact reflex analysis
- Electromagnetic therapy
- Herbal, vitamin, or dietary products or therapies
- Holistic medicine
- Homeopathic medicine
- Hypnotism
- Iridology - study of the iris
- Magnetic innervation therapy
- Massage therapy
- Naturopathy
- Neurofeedback / Biofeedback
- Orthomolecular therapy
- Reiki therapy
- Rolfing
- Thermography
- Art therapy, music therapy, dance therapy, horseback therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative

Medicine (NCCAM) of the National Institutes of Health.

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

Chiropractic Care
The following services are not covered when performed or ordered by a chiropractor:

- Charges for care not provided in an office setting
- Manipulation under anesthesia
- Maintenance or preventive treatment consisting of routine, long term or Non-Medically Necessary care provided to prevent reoccurrences or to maintain the patient's current status
- Vitamin or supplement therapy
- Supplies ordered by a chiropractor
- Infusion therapy or chelation therapy

This exclusion does not apply to those Covered Services that would be covered under the Chiropractic Care benefit.

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.

Note: This exclusion does not apply to Hospice care.

Dental Care
Dental care, except as defined under the *Pediatric Dental Care* section, (which includes dental x-rays, supplies, appliances, and all associated expenses, including hospitalizations and anesthesia) is not covered. If You have purchased a plan that includes Adult Dental coverage, refer to your Schedule of Benefits for information about dental services available to You.

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.
- Direct treatment of cancer or cleft lip or cleft palate.

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

Endodontics, periodontal surgery, and restorative treatment are excluded except as defined under the *Pediatric Dental Care* section.

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

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

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

Dental braces (orthodontics) for adults are not covered except as defined under the *Pediatric Dental Care* section, or when Medically Necessary.

Treatment of congenitally missing, mal-positioned, or supernumerary teeth for adults are excluded.

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

This exclusion does not apply to dental services required for the direct treatment of a medical condition such as treatment for cleft lip or cleft palate for which Benefits are described in the *Cleft Lip and Cleft Palate Treatment* section, or for accident related dental.

Devices, Appliances
Health care services excluded under this provision include the following devices or appliances, even when prescribed by a Physician:

- Corrective shoes and orthotic devices for podiatric use and arch supports, except for shoes for diabetics.
- Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Devices used specifically as safety items or to affect performance in sports-related activities.
- Enuresis alarm.
- Home coagulation testing equipment.
- Non-wearable external defibrillator.
- Oral appliances to treat sleep apnea or snoring.
- Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics (except for shoes for diabetics), cranial banding and some types of braces, including over-the-counter orthotic braces. This does not apply to equipment for the treatment of positional plagiocephaly.
- TMJ Disorder device or appliance that reposition the teeth, except an occlusal orthotic devise for temporomandibular pain, dysfunction, or associated musculature under the *Pediatric Dental Care* section .
- Trusses
- Ultrasonic nebulizers

Directed Blood Donations
Directed blood donations are excluded from coverage.

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

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

- It has been approved by the FDA as an “investigational new drug for treatment use.”
- It is classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a “life-threatening disease” as that term is defined in FDA regulations.

This exclusion **does not** apply to drugs that have been approved by the FDA as an investigational new drug for treatment use, drugs classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a life-threatening disease, or Covered Health Services provided during a clinical trial as described under the *Benefits/Coverage (What is Covered)* section of this Policy.

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

- Routine foot care, such as cutting or removal of corns and calluses, nail trimming, cutting, or debriding, except when performed specifically for the purpose of treating pain related to functional limitations
- Hygienic and preventive maintenance foot care. Examples include:
  - Cleaning and soaking the feet
  - Applying skin creams in order to maintain skin tone
- Shoes (except for shoes for diabetics or when the shoes are part of a leg brace and fitting)
- Treatment of flat feet, fallen arches, weak feet, taprsaligia, metatarsalgia and hyperkeratosis

This exclusion does not apply to foot care services provided in relation to vascular disease or diabetes for which coverage is provided per the *Benefits/Coverage (What is Covered)* section of this Policy.

Genetic Testing
Genetic testing is excluded unless it is Medically Necessary for the identification of genetically linked inheritable disease. Refer to the *Genetic Testing* and *Preventive and Wellness Services* sections of this Policy for information about Genetic Testing that is covered by the plan.

Hearing Aids
Services excluded under this section are the purchase cost and associated fitting and testing charges for Hearing Aids, Bone Anchor Hearing Aids (BAHA), and all other hearing assistive devices.

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

- Services to reverse voluntary, surgically induced infertility.
- All services and supplies (other than artificial insemination) related to conception by artificial means. This means prescription drugs related to such services such as, but not limited to, in vitro fertilization, ovum transplants, gamete intra fallopian transfer, and zygote intra fallopian transfer are not covered. These exclusions apply to fertile and infertile individuals or couples.
- Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
- Surrogate parenting, donor eggs, donor sperm, and host uterus, except when the surrogate is insured under this plan.
- Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue, and ovarian tissue.
- Fetal reduction surgery.
- Genetic testing of embryos pre- or post-implantation.
- Medications to treat sexual dysfunction.

Medical Supplies and Equipment
Health care services excluded under this provision include prescribed or non-prescribed medical supplies and disposable supplies, unless provided through Home Health Care.
Examples of supplies are:

- Ace bandages
- Adhesive
- Adhesive remover
- Antiseptics
- Appliance cleaners
- Deodorants (except for ostomy)
- Elastic stockings
- Filters

- Gauze and dressings
- Lubricants
- Tape

This exclusion does not apply to Durable Medical Equipment (DME) and Medical Supplies and Disposable Items coverage (i.e. tubing, masks, catheters).

Mental Health or Substance Use Disorder Services
This plan excludes the following services related to Mental Health or Substance Use Disorder treatment:

- Evaluations for purposes other than Mental Health treatment.
- School-based special education, counseling, therapy, or care for learning deficiencies or behavioral problems, whether associated with manifest mental disorder.
- Mental Health Services ordered by a court, to be used in a court proceeding, or as a condition of parole or probation, unless a plan Physician determines such services to be Medically Necessary.
- Court-ordered testing and testing for ability, aptitude, intelligence, or interest.
- Services which are custodial or residential in nature.

This exclusion does not apply to court-ordered testing that is Medically Necessary or for Mental Health and Substance Use Disorder Services covered in the *Mental Health and Substance Use Disorder Services* section of this Policy.

Nutrition
Health care services excluded under this provision include :

- Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
  - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
  - There exists a knowledge deficit regarding the disease that requires the intervention of a trained health professional.
- Infant formula and donor breast milk except for babies in neo-natal intensive care or under special care.
- Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

This exclusion does not apply to covered items in the *Diabetes Services, Infusion Therapy Services, Preventive and Wellness Services and Home Health Care* sections in this Policy.

Nutritional or Dietary Supplements
Nutritional and/or dietary supplements, except as described in this policy or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

Other Services
Health care services excluded under this provision include:

- 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. Premium for such person on active military duty will be refunded on a pro rata basis upon receipt of a written notice of military service.

Pediatric Dental Care – Limitations
Diagnostic and Preventive Services are limited as follows:

- D0120 Periodic oral evaluation - Limited to one every six months
- D0140 Limited oral evaluation - problem focused - Limited to one every six months

- D0150 Comprehensive oral evaluation - Limited to one every six months
- D0180 Comprehensive periodontal evaluation - Limited to one every six months
- D0210 Intraoral – complete series (including bitewings) one every 60 months
- D0220 Intraoral - periapical first film
- D0230 Intraoral - periapical - each additional film
- D0240 Intraoral - occlusal film
- D0270 Bitewing - single film - Adult -1 set every calendar year / Children - one set every six months
- D0272 Bitewings - two films - Adult -1 set every calendar year / Children - one set every six months
- D0274 Bitewings - four films Adult -1 set every calendar year / Children - one set every six months
- D0277 Vertical bitewings – 7 to 8 films – Adult -1 set every calendar year / Children - one set every six months
- D0330 Panoramic film – one film every 60 months
- D0340 Cephalometric x-ray
- D0350 Oral / Facial Photographic Images
- D0470 Diagnostic Models
- D1110 Prophylaxis – Adult - Limited to one every six months
- D1120 Prophylaxis – Child - Limited to one every six months
- D1203 Topical application of fluoride (excluding prophylaxis) – Child - Limited once every 6 months up to age 19
- D1204 Topical application of fluoride (excluding prophylaxis) – up to age 19 - once every 6 months
- D1206 Topical fluoride varnish - Over age 22 - 1 in 12 months; Less than age 22 - two in 12 months
- D1351 Sealant - per tooth - unrestored permanent molars - Less than age 19 - one sealant per tooth every 36 months
- D1352 Preventative resin restorations in a moderate to high caries risk patient - permanent tooth - one sealant per tooth every 36 months
- D1510 Space maintainer – fixed – unilateral - Limited to children under age 19
- D1515 Space maintainer – fixed – bilateral - Limited to children under age 19
- D1520 Space maintainer - removable – unilateral - Limited to children under age 19
- D1525 Space maintainer - removable – bilateral - Limited to children under age 19
- D1550 Re-cementation of space maintainer - Limited to children under age 19

Basic Services are limited as follows:

- D2140 Amalgam - one surface, primary or permanent
- D2150 Amalgam - two surfaces, primary or permanent
- D2160 Amalgam - three surfaces, primary or permanent
- D2161 Amalgam - four or more surfaces, primary or permanent
- D2330 Resin–based composite - one surface, anterior
- D2331 Resin-based composite - two surfaces, anterior
- D2332 Resin-based composite - three surfaces, anterior
- D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior)
- D2391 Resin-based composite restoration – one surface, posterior
- D2392 Resin-based composite restorations – two surfaces, posterior
- D2910 Re-cement inlay
- D2920 Re-cement crown
- D2930 Prefabricated stainless steel crown - primary tooth –Limited to one per tooth in 60 months
- D2931 Prefabricated stainless steel crown - permanent tooth - Limited to one per tooth in 60 months
- D2940 Protective Restoration
- D2951 Pin retention - per tooth, in addition to restoration
- D3220 Therapeutic pulpotomy (excluding final restoration) - If a root canal is within 45

days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and Benefits are not payable separately.

- D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and Benefits are not payable separately.
- D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth and for primary molars and cuspids and is limited to once per tooth per lifetime.
- D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when You discontinue treatment. - Limited to primary incisor teeth and for primary molars and cuspids and is limited to once per tooth per lifetime.
- D4341 Periodontal scaling and root planning-four or more teeth per quadrant – Limited to one every 24 months
- D4342 Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to one every 24 months
- D4910 Periodontal maintenance – four in 12 months combined with adult prophylaxis after the completion of active periodontal therapy
- D5410 Adjust complete denture – maxillary
- D5411 Adjust complete denture – mandibular
- D5421 Adjust partial denture – maxillary
- D5422 Adjust partial denture - mandibular
- D5510 Repair broken complete denture base
- D5520 Replace missing or broken teeth - complete denture (each tooth)
- D5610 Repair resin denture base
- D5620 Repair cast framework
- D5630 Repair or replace broken clasp
- D5640 Replace broken teeth - per tooth
- D5650 Add tooth to existing partial denture
- D5660 Add clasp to existing partial denture
- D5710 Rebase complete maxillary denture - Limited to one in a 36-month period six months after the initial installation
- D5720 Rebase maxillary partial denture - Limited to one in a 36-month period six months after the initial installation
- D5721 Rebase mandibular partial denture - Limited to one in a 36-month period six months after the initial installation
- D5730 Reline complete maxillary denture - Limited to one in a 36-month period six months after the initial installation
- D5731 Reline complete mandibular denture - Limited to one in a 36-month period six months after the initial installation
- D5740 Reline maxillary partial denture - Limited to one in a 36-month period six months after the initial installation
- D5741 Reline mandibular partial denture - Limited to one in a 36-month period six months after the initial installation
- D5750 Reline complete maxillary denture (laboratory) - Limited to one in a 36-month period six months after the initial installation
- D5751 Reline complete mandibular denture (laboratory) - Limited to one in a 36-month period six months after the initial installation
- D5760 Reline maxillary partial denture (laboratory) - Limited to one in a 36-month period six after the initial installation
- D5761 Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to one in a 36-month period six months after the initial installation.
- D5850 Tissue conditioning (maxillary)
- D5851 Tissue conditioning (mandibular)
- D6930 Recement fixed partial denture
- D6980 Fixed partial denture repair, by report

- D7140 Extraction, erupted tooth, or exposed root (elevation and/or forceps removal)
- D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
- D7220 Removal of impacted tooth - soft tissue
- D7230 Removal of impacted tooth – partially bony
- D7240 Removal of impacted tooth - completely bony
- D7241 Removal of impacted tooth - completely bony with unusual surgical complications
- D7250 Surgical removal of residual tooth roots (cutting procedure)
- D7251 Coronectomy - intentional partial tooth removal
- D7270 Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
- D7280 Surgical access of an unerupted tooth
- D7310 Alveoloplasty in conjunction with extractions - per quadrant
- D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
- D7320 Alveoloplasty not in conjunction with extractions - per quadrant
- D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
- D7471 Removal of exostosis
- D7510 Incision and drainage of abscess - intraoral soft tissue
- D7910 Suture of recent small wounds up to 5 cm
- D7971 Excision of pericoronal gingiva
- D9110 Palliative treatment of dental pain – minor procedure

Major Services are limited as follows:

- D0160 Detailed and extensive oral evaluation - problem focused, by report
- D2510 Inlay - metallic – one surface – An alternate Benefit will be provided
- D2520 Inlay - metallic – two surfaces – An alternate Benefit will be provided
- D2530 Inlay - metallic – three surfaces – An alternate Benefit will be provided
- D2542 Onlay - metallic - two surfaces – Limited to one per tooth every 60 months
- D2543 Onlay - metallic - three surfaces – Limited to one per tooth every 60 months
- D2544 Onlay - metallic - four or more surfaces – Limited to one per tooth every 60 months
- D2740 Crown - porcelain/ceramic substrate - Limited to one per tooth every 60 months
- D2750 Crown - porcelain fused to high noble metal - Limited to one per tooth every 60 months
- D2751 Crown - porcelain fused to predominately base metal – Limited to one per tooth every 60 months
- D2752 Crown - porcelain fused to noble metal – Limited to one per tooth every 60 months
- D2780 Crown - 3/4 cast high noble metal – Limited to one per tooth every 60 months
- D2781 Crown - 3/4 cast predominately base metal – Limited to one per tooth every 60 months
- D2783 Crown - 3/4 porcelain/ceramic – Limited to one per tooth every 60 months
- D2790 Crown - full cast high noble metal– Limited to one per tooth every 60 months
- D2791 Crown - full cast predominately base metal – Limited to one per tooth every 60 months
- D2792 Crown - full cast noble metal– Limited to one per tooth every 60 months
- D2794 Crown – titanium– Limited to one per tooth every 60 months
- D2950 Core buildup, including any pins– Limited to one per tooth every 60 months
- D2954 Prefabricated post and core, in addition to crown– Limited to one per tooth every 60 months
- D2980 Crown repair, by report
- D3310 Anterior root canal (excluding final restoration)
- D3320 Bicuspid root canal (excluding final restoration)
- D3330 Molar root canal (excluding final restoration)
- D3346 Retreatment of previous root canal therapy-anterior

- D3347 Retreatment of previous root canal therapy-bicuspid
- D3348 Retreatment of previous root canal therapy-molar
- D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
- D3352 Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
- D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
- D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
- D3410 Apicoectomy/periradicular surgery - anterior
- D3421 Apicoectomy/periradicular surgery - bicuspid (first root)
- D3425 Apicoectomy/periradicular surgery - molar (first root)
- D3426 Apicoectomy/periradicular surgery (each additional root)
- D3450 Root amputation - per root
- D3920 Hemisection (including any root removal) - not including root canal therapy
- D4210 Gingivectomy or gingivoplasty – four or more teeth - Limited to one every 2 years
- D4211 Gingivectomy or gingivoplasty – one to three teeth
- D4240 Gingival flap procedure, four or more teeth – Limited to one every 36 months
- D4249 Clinical crown lengthening-hard tissue
- D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to one every 36 months
- D4270 Pedicle soft tissue graft procedure
- D4271 Free soft tissue graft procedure (including donor site surgery)
- D4273 Subepithelial connective tissue graft procedures (including donor site surgery)
- D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis – Limited to one per year (12 months)

Orthodontic & Prosthodontic Services are limited as follows:

- D5110 Complete denture - maxillary – Limited to one every 60 months
- D5120 Complete denture - mandibular – Limited to one every 60 months
- D5130 Immediate denture - maxillary – Limited to one every 60 months
- D5140 Immediate denture - mandibular – Limited to one every 60 months
- D5211 Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth) – Limited to one every 60 months
- D5212 Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth) – Limited to one every 60 months
- D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests, and teeth)– Limited to one every 60 months
- D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests, and teeth) – Limited to one every 60 months
- D5281 Removable unilateral partial denture - one-piece cast metal (including clasps and teeth) – Limited to one every 60 months
- D6010 Endosteal Implant - one every 60 months
- D6012 Surgical Placement of Interim Implant Body - one every 60 months
- D6040 Eposteal Implant – one every 60 months
- D6050 Transosteal Implant, Including Hardware – one every 60 months
- D6053 Implant supported complete denture
- D6054 Implant supported partial denture
- D6055 Connecting Bar – implant or abutment supported - one every 60 months
- D6056 Prefabricated Abutment – one every 60 months
- D6058 Abutment supported porcelain ceramic crown - one every 60 months
- D6059 Abutment supported porcelain fused to high noble metal - one every 60 months
- D6060 Abutment supported porcelain fused to predominately base metal crown - one every 60 months
- D6061 Abutment supported porcelain fused to noble metal crown - one every 60 months

- D6062 Abutment supported cast high noble metal crown - one every 60 months
- D6063 Abutment supported cast predominately base metal crown - one every 60 months
- D6064 Abutment supported cast noble metal crown - one every 60 months
- D6065 Implant supported porcelain/ceramic crown - one every 60 months
- D6066 Implant supported porcelain fused to high metal crown - one every 60 months
- D6067 Implant supported metal crown - one every 60 months
- D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture - one every 60 months
- D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - one every 60 months
- D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - one every 60 months
- D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture - one every 60 months
- D6072 Abutment supported retainer for cast high noble metal fixed partial denture one every 60 months
- D6073 Abutment supported retainer for predominately base metal fixed partial denture - one every 60 months
- D6074 Abutment supported retainer for cast noble metal fixed partial denture - one every 60 months
- D6075 Implant supported retainer for ceramic fixed partial denture - one every 60 months
- D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture - one every 60 months
- D6077 Implant supported retainer for cast metal fixed partial denture - one every 60 months
- D6078 Implant/abutment supported fixed partial denture for completely edentulous arch - one every 60 months
- D6079 Implant/abutment supported fixed partial denture for partially edentulous arch - one every 60 months
- D6080 Implant Maintenance Procedures -one every 60 months
- D6090 Repair Implant Prosthesis -one every 60 months
- D6091 Replacement of Semi-Precision or Precision Attachment -one every 60 months
- D6095 Repair Implant Abutment -one every 60 months
- D6100 Implant Removal -one every 60 months
- D6190 Implant Index -one every 60 months
- D6210 Pontic - cast high noble metal – Limited to one every 60 months
- D6211 Pontic - cast predominately base metal – Limited to one every 60 months
- D6212 Pontic - cast noble metal– Limited to one every 60 months
- D6214 Pontic – titanium – Limited to one every 60 months
- D6240 Pontic - porcelain fused to high noble metal – Limited to one every 60 months
- D6241 Pontic - porcelain fused to predominately base metal – Limited to one every 60 months
- D6242 Pontic - porcelain fused to noble metal – Limited to one every 60 months
- D6245 Pontic - porcelain/ceramic – Limited to one every 60 months
- D6519 Inlay/onlay – porcelain/ceramic – Limited to one every 60 months
- D6520 Inlay – metallic – two surfaces – Limited to one every 60 months
- D6530 Inlay – metallic – three or more surfaces - Limited to one every 60 months
- D6543 Onlay – metallic – three surfaces - one every 60 months
- D6544 Onlay – metallic – four or more surfaces -one every 60 months
- D6545 Retainer - cast metal for resin bonded fixed prosthesis -one every 60 months
- D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis -one every 60 months
- D6740 Crown - porcelain/ceramic - one every 60 months
- D6750 Crown - porcelain fused to high noble metal - one every 60 months
- D6751 Crown - porcelain fused to predominately base metal - one every 60 months
- D6752 Crown - porcelain fused to noble metal - one every 60 months

- D6780 Crown - 3/4 cast high noble metal - one every 60 months
- D6781 Crown - 3/4 cast predominately base metal - one every 60 months
- D6782 Crown - 3/4 cast noble metal - one every 60 months
- D6783 Crown - 3/4 porcelain/ceramic - one every 60 months
- D6790 Crown - full cast high noble metal - one every 60 months
- D6791 Crown - full cast predominately base metal - one every 60 months
- D6792 Crown - full cast noble metal - one every 60 months
- D6973 Core buildup for retainer, including any pins - one every 60 months
- D8010 Limited orthodontic treatment of the primary dentition
- D8020 Limited orthodontic treatment of the transitional dentition
- D8030 Limited orthodontic treatment of the adolescent dentition
- D8050 Interceptive orthodontic treatment of the primary dentition
- D8060 Interceptive orthodontic treatment of the transitional dentition
- D8070 Comprehensive orthodontic treatment of the transitional dentition
- D8080 Comprehensive orthodontic treatment of the adolescent dentition
- D8210 Removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)
- D8220 Fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)
- D8660 Pre-orthodontic treatment visit
- D8670 Periodic orthodontic treatment visit (as part of contract)
- D8680 Orthodontic retention (removal of appliances, construction, and placement of retainer(s)
- D9940 Occlusal guard, by report - for grinding and clenching of teeth

Other General Dental Services/Component Procedures

Cost-sharing for these services apply the same cost-share as the primary procedure being performed.

- D9220 Deep sedation/general anesthesia - first 30 minutes
- D9221 Deep sedation/general anesthesia - each additional 15 minutes
- D9241 Intravenous conscious sedation/analgesia - first 30 minutes
- D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes
- D9310 Consultation (diagnostic service provided by dentist or Physician other than practitioner providing treatment)
- D9610 Therapeutic drug injection, by report
- D9930 Treatment of complications (post-surgical) unusual circumstances, by report

Additional limitations that apply to Pediatric Dental Services:

- 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
    - 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 gingiv al inflammation are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed

following active periodontal therapy.

- X-ray limitations:
  - The plan will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
  - When a panoramic film is submitted with supplemental film(s), the plan will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
  - 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.
- The fee for pulp vitality tests is 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 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.
- Repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement.
- Specialist consultations count toward the oral exam frequency.
- We will not cover replacement of an amalgam or resin-based composite restorations (fillings) within 12 months of treatment if the service is provided by the same Provider/Provider office.
- Replacement restorations within 12 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.
- Retreatment of root canal or pulpal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.
- 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:
  - 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 planning 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.
  - 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.
- 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.
- When allowed within six 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.

- Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
- Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under this program 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.
- 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.
- 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 months of the initial placement.
- 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 months after placement.
- Tissue conditioning is not allowed as a separate Covered Service when performed on the same day as a denture reline or rebase service.

Pediatric Dental Care – Exclusions

The Pediatric Dental Care plan will not pay Benefits for:

- D0322 Tomographic survey
- D0360 Cone Beam CT
- D0362 Cone Beam multiple images 2 dim.
- D0363 Cone Beam multiple images 3 dim.
- D0416 Viral culture
- D0418 Analysis of saliva example chemical or biological analysis of saliva for diagnostic purposes
- D0425 Caries test
- D0431 Adjunctive pre-diagnostic test
- D0475 Declassification procedure
- D0476 Special stains for microorganisms
- D0477 Special stains not for microorganisms
- D0478 Immunohistochemical stains
- D0479 Tissue in-situ-hybridization
- D0481 Electron microscopy
- D0482 Direct immunofluorescence
- D0483 In-direct immunofluorescence
- D0484 Consultation on slides prepared elsewhere
- D0485 Consultation including preparation of slides
- D0486 Accession Transepithelial
- D1310 Nutritional counseling
- D1320 Tobacco counseling
- D1330 Oral Hygiene Instruction
- D1555 Removal of fixed space maintainer
- D2410 Gold Foil 1 surface
- D2420 Gold Foil 2 surface
- D2430 Gold Foil 3 surface
- D2799 Provisional Crown
- D2955 Post Removal
- D2970 Temporary Crown
- D2975 Coping
- D3460 Endodontic Implant

- D3470 Intentional reimplantation
- D3910 Surgical procedure for isolation of tooth
- D3950 Canal preparation
- D4230 Anatomical crown exposure 4 or more teeth
- D4231 Anatomical crown exposure 1-3 teeth
- D4320 Splinting intracoronal
- D4321 Splinting extracoronal
- D5810 Complete denture upper (interim)
- D5811 Complete denture lower (interim)
- D5820 Partial denture upper (interim)
- D5821 Partial denture lower (interim)
- D5862 Precision Attachment
- D5867 Replacement Precision Attachment
- D5986 Fluoride Gel Carrier
- D6057 Custom abutment
- D6253 Provisional Pontic
- D6254 Interim pontic
- D6795 - Interim retainer crown
- D6920 Connector bar
- D6940 Stress breaker
- D6950 Precision Attachment
- D6975 Coping - metal
- D7292 Surgical replacement screw retained
- D7293 Surgical replacement w/surgical flap
- D7294 Surgical replacement without the surgical flap
- D7951 Sinus Augmentation with bone or bone substitutes
- D7997 Appliance Removal
- D7998 Intraoral placement of a fixation device
- 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.
- Office infection control charges.
- Charges for copies of Your records, charts or x-rays, or any costs associated with forwarding/mailing 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.
- Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from military service for any country or organization.
- 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 aides 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.
- 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.
- 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 are subject to the usual and customary maximum allowable fee charges as defined by Us, Except for Emergency Health Services, if You are treated by a Non-Network Provider while 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. The member is responsible for all remaining charges that exceed the allowable maximum.
- 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.
- Services and treatment which are Experimental or Investigational.
- 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 exceed Benefit limitations.
- 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, or Convenience

Items excluded under this provision include:

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

Physical Appearance
Health care services excluded under this provision include the following:

- Cosmetic Procedures. See the definition in the *Definitions* section. Examples include:
  - Pharmacological regimens, nutritional procedures, or treatments.
  - Scar or tattoo removal or revision procedures (such as salabrasion, laser removal, chemosurgery, and other such skin abrasion procedures).
  - Skin abrasion procedures performed as a treatment for acne.
  - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
  - Treatment for skin wrinkles or any treatment to improve the appearance of the skin, including blepharoplasty, or eyelid surgery.
  - Treatment for spider veins or varicose veins. This includes, but is not limited to, vein stripping, laser procedures, or surgery.
  - Fat injections, fat grafting.
  - Hair removal or replacement by any means.
- Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.
- Treatment of benign gynecomastia (abnormal breast enlargement in males).
- Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery that is required to treat a physiologic functional impairment or which is required by the *Women's Health and Cancer Right's Act of 1998* and described under the *Benefits/Coverages (What is Covered)* section of this Policy.
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

- Wigs, toupees, hair transplants, or hair weaving, except as covered under Prosthetic Devices for Covered Persons undergoing treatment for cancer or other conditions treated by chemotherapy or radiation therapy.

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

Prescription Drugs
Health care services excluded under this provision include:

- Any product dispensed for the purpose of appetite suppression or weight loss.
- 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.
- Biological sera, blood, blood products, or plasma. These would be covered under your Plan as a medical benefit, not a prescription drug benefit.
- Drugs classes in which at least one drug in the class is available over-the-counter
- Early prescription refills to replace a lost, stolen, or destroyed prescription or prescription supplies, or exceeding the Days' Supply Limit, Quantity or Supply Limits.
- General vitamins except as described under the "Preventive and Wellness Services" provision of the *Benefits/Coverage (What is Covered)* section of this Policy.
- Human Growth Hormone prescribed to adults, unless Medically Necessary .
- Marijuana, including but not limited to medical marijuana for any reason.
- Medication prescribed for the treatment of hair loss.
- Medications available as bulk powder only.
- Medications for conditions that are excluded from coverage.
- Medications not approved by the FDA as an investigational new drug for treatment use or drugs classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a life-threatening disease.
- Medications used to treat erectile dysfunction.

- Medications to treat hyperhidrosis.
- Medications which are labeled or deemed Investigational or Experimental, including regimens that are unproven.
- Medications determined to be ineffective, unproven, or unsafe. Drugs with no approved FDA indications and DESI (Drug Efficacy Study Implementation) products, i.e. those rated by the FDA has not proven safe and effective.
- Medications prescribed solely for cosmetic purposes.
- Medications used for prevention of diseases not endemic to United States.
- Medications used to treat Sexual Dysfunction.
- Medications new to market until reviewed by the Pharmacy and Therapeutics Committee.
- Non-Prescription Medications (medications that do not require a prescription), unless specifically included as covered elsewhere in this document or mandated by law.
- Off-Label Use of medications unless required by law, then allowed in accordance with law.
- Prescribed and non-prescribed outpatient supplies, other than diabetic supplies and inhaler spacers specifically stated as covered.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Prescription Drug Products for any condition, Injury, Sickness, or Mental Illness arising out of, or in the course of, employment for which Benefits have been paid under any workers' compensation law or other similar laws.
- Prescription Drug Products furnished by local, state, or federal government. Any Prescription Drug Product to the extent payment or Benefits is provided or available from the local, state, or federal government (e.g., Medicare) whether or not payment or Benefits are received, except as otherwise provided by Medicaid.
- Prescription Drug Products obtained through a Non-Network Pharmacy.
- 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.
- Prescription drugs with a non-prescription equivalent except as described under the *Preventive and Wellness Services* provision of the *Benefits/Coverage (What is Covered)* section of this Policy.
- Topical medications for the treatment of onychomycosis of the toenails.
- Unit-dose or re-packaged medications, or costs related to re-packaging of available covered medications.

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

- 90-day supply of covered medications per prescription is allowed, other Quantity Limits may be applied to claims, with the exception for a 12-month supply of FDA-approved self-administered hormonal contraceptives.
- Certain medications are subject to Our utilization review process and quantity limits. In addition, certain medications may be subject to any quantity limits applied as part of our split fill program. For most medications, 90-day supplies will be covered when filled at a network pharmacy. No more than a 30-day supply of Specialty Medications will be covered and dispensed at a time.
- If a member or Provider requests a brand medication when there is a Generic equivalent, the member will be responsible for the tier 3 cost share plus the difference in drug cost between the brand and generic.
- The member Copayment for a medication will not exceed the cost of the medication

Private Duty Nursing
Private duty nursing provided in an inpatient setting.

Procedures and Treatments
Health care services excluded under this provision include the following:

- Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures such as 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.
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or Medically Necessary treatment of TMJ, dislocation, tumors, orthognathic surgery, jaw alignment, or cancer.
- Remote surgical neuromonitoring.

Providers
- Services performed by a Provider who is an immediate family member by birth or marriage. This includes any service the Provider may perform on himself or herself.
- Services provided at a freestanding or Hospital-based diagnostic Facility without an order written by a Physician or other Provider, except for Emergency Services. 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
  - Is not actively involved in Your medical care after the service is received.

This exclusion does not apply to mammography.

Self-Directed Diagnostic Testing
Self-directed diagnostic testing such as laboratory, x-ray, and radiology services performed for diagnostic purposes without the order of a treating Physician are excluded from coverage under this plan.

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

Services Rendered by a Non-Network Provider
Generally, services from Non-Network Providers are not covered. Exceptions to this exclusion are:
- Emergency Health Services
- You are treated by a Non-Network Provider while receiving care at a Network Facility
- 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 excluded under this provision.

Sexual Dysfunction
Services, supplies or drugs for male or female sexual problems such as enhance performance or increase sexual desire.

Transplantation Services
Health care services excluded under this provision include:
-
- 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. When the donor is a non-covered member and the person receiving the organ is covered, benefits are limited to benefits not available to the donor from any other source.
- Transplant services that are not performed at a Designated Facility. This exclusion does not apply to corneal transplants.

Travel
Health care services excluded under this provision include:

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

Types of Care
Health care services excluded under this provision include:

- Respite care, except as covered under the Hospice Care provision of the *Benefits/Coverages (What is Covered)* section of this Policy
- Rest cures
- Services of personal care attendants
- Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work)

Vision Services
Health care services excluded under this provision include:

- Purchase cost and fitting charge for eyeglasses, frames, or contact lenses, except as covered under *Pediatric Vision Services* provision in this Policy. If You have purchased a plan that includes Adult Vision coverage, refer to your Schedule of Benefits for information about vision services available to You.
- Adult eye exams except when Medically Necessary and performed by an ophthalmologist for medical conditions of the eye, not including keratoconus. If You have purchased a plan that includes Adult Vision coverage, refer to your Schedule of Benefits for information about vision services available to You.
- Implantable devices used to correct a refractive error (such as Intacs corneal implants).
- Eye exercise therapy.
- Surgery that is intended to allow You to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

These exclusions are not applicable to coverage for services included in the *Vision Correction After Surgery or Accident* section.

All Other Exclusions
Items excluded under this provision include:

- Administrative services
- Aids or devices that assist with non-verbal communications.
- Ambulance services that are not Medically Necessary.
- Charges for services provided by a stand-by Physician.
- Charges in excess of the Allowed Amount or in excess of any specified limitation.
- Complications of non-covered services, meaning care that is needed as a direct result of a non-covered service and without the non-covered service, care would not have been needed.
- Court-ordered testing, except for mental health or Substance Use Disorder testing or treatment as required by state law.
- Educational, vocational or self-training services or supplies, except as otherwise specifically covered.
- Free care.
- Gym fees or memberships.
- Health services and supplies that do not meet the definition of a Covered Health Service as noted in the *Definitions* section of this Policy.
- Health services received as a result of war or any act of war including nuclear accident, whether declared or undeclared or caused during service in the armed forces of any country.

- Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
- Home care services that are not rendered under an approved arrangement with a home health worker, including homemaker services, housing and food delivered meals. This does not apply to Hospice Care.
- Inpatient stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- Long-term care/nursing home care
- Long-term (more than 30 days) storage of products such as cryopreservation of tissue, blood, and blood products.
- Medical services and procedures that are not legal.
- Missed and canceled appointments.
- Non-interactive telemedicine services, such as audio-only telephone conversations, electronic mail or fax transmissions.
- Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are Solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage, or adoption, or that are:
    - Related to judicial or administrative proceedings or orders unless Medically Necessary and for covered services under this Policy.
    - Conducted for purposes of medical research.
    - Required to obtain or maintain a license of any type.
- Preventive Care services rendered by an Out-of-Network Provider or at an Out-of-Network Facility.
- Services performed as a result of complications related to or attributable to services that are specifically excluded from coverage under this Policy.
- Services prescribed, ordered, referred or given by an immediate family member.
- Virtual colonoscopy 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 8 – Member Payment Responsibility

Your Responsibilities

Show Your ID Card
Show Your 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. Review the *Limitations/Exclusions (What is Not Covered)* section so You know what is not covered.

Our Responsibilities

Pay Our Portion of the Cost of Covered Health Services
We pay for the Covered Health Services listed in the Schedule of Benefits. Additional information is available in the *What is Covered* section. Not all health care services are covered by the plan. Services considered Medically Necessary may not be covered or certain limitations may 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 with Us for payment. When You receive health services from Network Providers, You do not have to send Us a claim.

Offer Health Education Services to You
As a member of Our plan We may send You information about other services such as 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 9 – Claims Procedure (How to File a Claim)

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

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

Notice of Claim for Reimbursement
Written notice of claim must be furnished to Us within 20 days after the occurrence, or as soon thereafter as reasonably possible. The notice can be given to the Company at:

Bright Health Insurance Company
P.O. Box 1519
Portland, ME 04104

Electronic submission of the notice of claim or proof of loss is acceptable as submission on paper.

There is no paperwork for claims for services from Network Providers. You will need to show Your ID card and pay any required Copayment. Your Network Provider will submit a claim to Us for reimbursement. Claims for Emergency Services from Non-Participating Providers can be submitted by the Provider if the Provider is able and willing to file on Your behalf.

Proof of Loss
Written proof of loss must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, the Company shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

Time of Payment of Claims
Benefits for any loss covered by this policy will be paid as soon as the Company received proper written proof.

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.
When we receive Your notice of a claim, we may request all of the following information:

- Date services were received.
- Date the Injury or Sickness began.
- ICD-10 diagnosis code from the Physician.
- ID number on Your ID card.
- Itemized bill from Your Provider that includes the Current Procedural Terminology (CPT) codes for each charge.
- Name and address of any ordering/referring Physician.
- Name, address, Tax ID, and NPI number of the Provider of the service(s).
- Patient's name and date of birth.
- Statement indicating that You either are or 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.
- Subscriber's name and address.

The required claim forms are available on Our Member Hub or by calling Customer Service at the number on Your ID card.

Payment of Claims
Benefits will be paid to You. Any benefits unpaid at death will be paid to the Covered Person's estate. If the Provider is a Network Provider, claims payments will be made to the Provider.

Timely Filing for Non-Network Providers
Claims for Covered Health Services from a Non-Network or Non-Participating Provider must be submitted to Us within the timely filing period set forth in the *Notice of Claim for Reimbursement* section. For any other loss, written proof must be given with 90 days after such loss as set forth in the *Proof of Loss* section. If it was not reasonable possible to give written proof in the time required, Bright Health Insurance shall not reduce or deny the claim for this reason if the proof is filed a soon as reasonable possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year (365 days) from the date specified. If Your Provider does not file a claim for You, You are responsible for filing the claim within 15 months. Claims submitted after the deadline are not eligible for Benefit payment or reimbursement. Claims can be submitted to Us at:

Bright Health Insurance Company
P.O. Box 1519
Portland, ME 04104

Section 10 – General Policy Provisions

Your Relationship with Us

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

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

Our Relationship with Providers

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

Your Relationship with Providers

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

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

Incentives to Providers

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

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

Incentives to You

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

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to You in Your home or in a Physician’s office, or at a Hospital, or Alternate Facility. This includes rebates for those drugs administered to You before You meet any applicable Annual Deductible. We do not pass these

rebates on to You, nor are they applied to any Annual Deductible or considered in determining Your Copayments or Coinsurance.

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

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

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

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

Evaluation of New Technology
Coverage for new technology that is Experimental, Investigational, or not deemed Medically Necessary is excluded from coverage.

We will evaluate the use 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. You must cooperate with those persons or entities in the performance of their responsibilities.

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

Physical Examination and Autopsy
We have the right at Our expense, to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

Integration of Medicare Benefits
If You are eligible for Medicare, Your Medicare eligibility will not affect the Covered Services covered under this Policy, except as follows:

- Your Medicare coverage will be applied first (primary) to any services that would be covered by both Medicare and this Policy.
- If You receive a service that would be covered both by Medicare and this Policy, We will allow no more than the amount allowed by Medicare for the same Covered Health Service when calculating Benefits payable under the terms of this Policy. All Benefits payable under this Policy are subject the applicable Deductible, Copayment, and/or Coinsurance for the Covered Health Service as outlined in the Schedule of Benefits.
- If You or a Dependent are entitled to Medicare or if a Member of this Policy becomes eligible for Medicare by reason of age, we will consider what Medicare would 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 would pay.

- If You or a Dependent are eligible for Medicare by reason of age, We will estimate the amount Medicare would have paid and reduce benefits by this amount for any Member who is eligible to enroll in Medicare but is not enrolled.

Coordination of Benefits (COB)

When Does Coordination of Benefits Apply?
This Coordination of Benefits (COB) provision applies when a Covered Person has health care coverage under more than one Plan, as described below.

Definitions
For purposes of this section, see the defined terms below:

Closed Panel Plan - a Plan that provides health care benefits to Covered Persons primarily in the form of services through a Provider Network that is contracted with or employed by the Plan, and that excludes benefits for services provided by Non-Network Providers, except in cases of emergency or Prior Authorization by the Plan.

Custodial Parent - the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Plan - any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

- Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; medical benefits under group or individual automobile contracts; or coverage under other federal governmental plans, unless permitted by law.

Primary Plan - the Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its Policy terms without consideration that another Plan may cover some expenses.

Secondary Plan- the Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowed Amount.

Order of Benefit Determination Rules
The order of benefit determination rules decides which Plan is Primary or Secondary when the Covered Person has health care coverage under more than one Plan.

When this Plan is primary, it determines payment for its benefits first. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowed Amount.

Determining the Order of Benefit Payments
When a Covered Person is enrolled in two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without consideration to benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a COB provision that is consistent with this provision may be deemed primary unless the provisions of both Plans state that the complying plan is primary. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:
    1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan. The Plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
    2. **Dependent Child Covered Under More Than One Coverage Plan**. Unless there is a court decree stating otherwise, plans covering a Dependent child shall determine the order of benefits as follows:
        a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
            (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
            (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
        b) For a Dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
            (1) If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the Dependent child's health care expenses, but that parent's spouse, Domestic Partner or legal partner does, that parent's spouse's, Domestic Partner's or legal partner's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
            (2) If a court decree states that both parents are responsible for the Dependent child's health care expenses or health

care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
   a) The Plan covering the Custodial Parent.
   b) The Plan covering the Custodial Parent's spouse, domestic partner or legal partner.
   c) The Plan covering the non-Custodial Parent.
   d) The Plan covering the non-Custodial Parent's spouse, domestic partner or legal partner.

c) For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a Dependent under a spouse's plan, the rule in paragraph (5) applies.
(ii) In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the Dependent child's parent(s) and the Dependent's spouse.

Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee (an employee who is neither laid off nor retired) is the Primary Plan. The same rule applies if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

COBRA or State Continuation Coverage. If a person whose coverage is provided by COBRA or another right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a Dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

Longer or Shorter Length of Coverage. The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

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, we will consider what Medicare will pay to

the extent permitted by law. This means that We will determine coverage and payment available to the Member after subtracting the amounts that Medicare will pay.

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

- Occupational disease laws
- Employer's liability policies
- Municipal, state or federal law
- Workers' Compensation Act

You must pursue Your rights under the Workers' Compensation Act or any other laws that may apply to Your situation.

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.

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

- If You have an appeal pending in front of the Virginia Department of Labor and Industry, We will pay claims for Covered Health Services under this Policy.
- If You qualify under Virginia 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.

In the event Worker’s Compensation denies benefits for coverage, Covered Health Services under this Policy will be considered for payment subject to Our reimbursement policies.

Other Insurance in this Company
Insurance effective at any one time on the Insured under a like policy or policies in this Company is limited to the one such policy elected by the Insured, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

Grace Period
A Grace Period of three months for individuals receiving Advance Payment Tax Credit will be allowed for the payment of all outstanding Premiums. If the full balance of outstanding Premium is not paid within the grace period, coverage will end on the last day of the first calendar month of the grace period. For non-subsidized members, a 31-day grace period will be allowed for the payment of all outstanding Premiums. If the full balance of outstanding Premium is not paid within the grace period, coverage will end on the last day of the Grace Period. We will provide You notice of Your nonpayment before cancelling Your Policy. We will not pay for any services received on or after the date Your coverage ends.

Unpaid Premiums
If there is any Premium due and unpaid when We pay a claim under this Policy, We may deduct the amount due from Our payment of the claim.

Limitation of Legal Action
No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Conformity with State Statutes
Bright Health is subject to regulation in Virginia by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and by the Virginia Department of Health pursuant to Title 32.1. Any provision of this Policy that, on its effective date, conflicts with the statutes of the State of Virginia is hereby amended to conform to the minimum requirements of such statutes.

Fraudulent Insurance Acts Notice

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

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

If fraud is suspected, contact Customer Service at the number listed in the *Contact Us* section of this Policy and on Your ID Card.

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

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

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

Cancellation by Insured
The Insured may cancel this policy at any time by written notice delivered or mailed to Us effective upon receipt or on such later date as may be specified in the Notice. In the event of cancellation, We shall promptly return the unearned portion of any premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

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

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

On its effective date this Policy replaces and overrules any Policy that We may have previously issued to You. Any Policy We issue to You in the future will in turn overrule this Policy. This Policy will take effect on the date specified on page 1 of 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 the grace period .

Laws Governing this Health Plan

This health plan is entered into in, and is subject to the laws of, the Commonwealth of Virginia and federal law where applicable.

Section 11 – 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 30-day or more advanced written notice prior to the termination of Your coverage, except if such termination is the result of fraud or intentional misrepresentation of material fact.

- You are actively enrolled under more than one of Our Individual plans. Coverage under the first plan will end as of the effective date of any subsequent Bright Health non-group plan.
- We decide to discontinue all of Our Individual plans in the State of Virginia. In this case, We will provide notice of the decision to discontinue 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 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 receive a written notice from You instructing Us to cancel Your or Your Dependent's coverage. If any Premium has been paid for the time period following the requested date of termination and no claims have been submitted to Us for dates of service after the requested date of termination, We will refund or credit that Premium within 30 days of the request for termination. In the case of retractive termination, We will not refund or credit any Premium when claims have been submitted to Us for dates of service after the requested date of termination.
- For Individual Policies (not Child-only): An Enrolled Dependent Child reaches age 26. If the Dependent Child is incapable of self-sustaining employment by reason of intellectual or physical disability and is chiefly dependent upon the Policyholder for support and maintenance, the Dependent can remain as a Dependent Child under the Policy. Proof of such dependency may be required within 31 days of the Child's attainment of the limiting age, but not more frequently than annually after the two (2) year period following age 26.
- The Spousal relationship, as referred to in Our definition of Spouse, is legally dissolved. Coverage for the Dependent Spouse will end on the last day of the month in which the Spousal relationship is legally dissolved. Once We receive notice of the dissolution, We will adjust Your coverage and Premium.
- For Individual Child-Only Policies: A Covered Person reaches age 21. Coverage for the Covered Person reaching age 21 will end on the last day of the month in which the Covered Person turns 21.
- In the event of the Subscriber's death, the Spouse of the Subscriber, if covered under the policy, shall become the Subscriber.
- Coverage will end if Premiums are not paid when they are due. A Grace Period of three months for individuals receiving Advance Payment Tax Credit will be allowed for the payment of all outstanding Premiums. If the full balance of outstanding Premium is not paid within Your grace period, coverage will end on the last day of the first calendar month of the grace period. For non-subsidized Members, a 31-day grace period will be allowed for the payment of all outstanding Premiums. If the full balance of outstanding Premium is not paid within Your grace period, coverage will end on the 31st day of the Grace Period. We will provide You notice of Your nonpayment before cancelling Your Policy. We will not pay for any services received on or after the date Your coverage ends.
- Fraud, such as 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 rescission of this Policy. Rescissions will be as of the coverage effective date, and it will be as if You were never covered under this Policy. We will provide You with 30 days written notice prior to rescinding coverage.

Reinstatement of Coverage

If the (non-subsidized) renewal premium is not paid before the Grace Period ends, the policy will lapse. Subsequent acceptance of Premium by Us without requiring an application for reinstatement, shall reinstate the Policy. 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 45th 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 renewal 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 60 days prior to the date of reinstatement.

Section 12 – Appeals and Complaints

Cultural and Linguistic Handling of Denials and Appeals
We are required to provide Culturally and Linguistically Appropriate Notices, which means that We will provide the following:

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

What to Do if You Have a Question
Contact Customer Service at the telephone number listed in the *Contact Us* section of this Policy and on Your ID Card. Customer Service representatives are available to take Your call and resolve Your inquiry.

What to Do if You Have a Complaint
Contact Customer Service at the telephone number listed in the *Contact Us* section of this Policy and on Your ID Card. Customer Service representatives are available to take Your call.

If You would rather send Your complaint to Us in writing, You may send a written request to Us at the address listed below:

Bright HealthCare
PO Box 1519
Portland, ME 04104

If the Customer Service representative cannot resolve the issue to Your satisfaction over the phone, the representative can help You prepare and submit a written complaint. We will notify You of Our decision regarding Your complaint within 30 days of receiving it, unless additional information is required for the review, in which a fourteen (14) calendar day extension may be taken.

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. Once You have gone through the internal appeal process, if further review is necessary, You may request an independent external review (See Independent External Review Process below for criteria).

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.
- 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:
  - Patient's name and the identification number from the ID Card
  - Date(s) of the medical service(s)

- Provider's name

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

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

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

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

Notice of Internal Appeal Determination
Within 30 calendar days of receipt of a preservice appeal and 60 calendar days of receipt of a post service appeal, We will provide You with a written notice of Our determination along with a detailed explanation of the basis for that determination and, if the Initial Adverse Determination was upheld, of the process for requesting an independent external review.

Expedited Appeals

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

An expedited appeal request does not need to be submitted in writing. An expedited review may be requested by calling the Customer Service number listed in the *Contact Us* section of this Policy and on Your ID Card.

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

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

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

We will confirm Our initial notification in a formal letter within three business days.

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

Independent External Review

Independent External Review Process
If You are not fully satisfied with the final decision of Our review regarding a utilization review decision, you may contact the Commission to request an external review. You may request an

external review within 120 days of receiving our notice of our final decision on your appeal. Your appeal will be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Us or any of Our affiliates. A decision to use the voluntary level of appeal will not affect Your rights to any other benefits under this Plan.

You will be considered to have exhausted the internal appeal process if You have:

- Completed Our internal appeal process
- Filed an appeal requesting a review of an Adverse Determination, and, except to the extent that You agreed to a delay, have not received a written decision from Us within 30 days for pre-service appeals and 60 days for post-service appeals, following the date the appeal was filed with Us.
- Filed a request for an expedited internal appeal of an Adverse Determination with Us. You may file a request for an expedited external review of the Adverse Determination at the same time.

A request for an external review of an Adverse Determination may be made before You have exhausted Our internal appeal process if We agree to waive the exhaustion requirement. If the exhaustion requirement is waived, You may file a request in writing for a standard external review. You are not required to exhaust Our internal Appeal process before seeking a standard or expedited External Review of an Adverse Determination involving the treatment of cancer.

The request for an external review must be submitted within 120 days of Your receipt of a final Adverse Determination. Adverse Determination in the context of external review means a determination has been made that an admission, availability of care, continued stay, or other health care service, based on the information provided, does not meet Our requirements for what is Medically Necessary, appropriateness, level of care, health care setting, effectiveness, or is determined to be Experimental or Investigational.

When filing a request for an external review, You will be required to authorize the release of Your medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

Independent External Review requests can be made by calling 1-877-310-6560 (toll free), or by emailing externalreview@scc.virginia.gov

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

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

Expedited Independent External Review

Expedited Independent External Review Process
You may be entitled to make a request for an Expedited External Appeal if You receive:

- an Adverse Determination if the Adverse Determination involves a medical condition for which the time frame for completion of a standard internal appeal involving an Adverse Determination would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function; or
- a final Adverse Determination if You have a medical condition where the time frame for completion of a standard external appeal would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, or if the final Adverse

Determination concerns an admission, availability of care, continued stay or health care service for which You received Emergency Services but have not been discharged from a facility.

Retrospective Adverse Determinations are not eligible for an expedited review. If Your request is approved for an Expedited Appeal, the Independent Review Organization assigned by the Virginia Bureau of Insurance will make a decision, as expeditiously as Your medical condition or circumstances requires, but in no event more than 72 hours after the date of receipt, to uphold or reverse the Adverse Determination. You, Bright Health and the Virginia Bureau of Insurance will be provided written notice within 48 hours after the date of providing the initial determination if the initial notification was not in writing.

Expedited Independent External Review requests can be made by calling 1-877-310-6560 (toll free), or by emailing externalreview@scc.virginia.gov

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

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

Important Notice – Claims Disputes

If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance.

Toll free phone: 1-877-310-6560, select option 1
or
Toll free in state calls: 1-800-552-7945

Email: ombudsman@scc.virginia.gov

Mailing Address:
Office of the Managed Care Ombudsman
Bureau of Insurance
PO Box 1157
Richmond, VA 23218

Section 13 – 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 making 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 , 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 Insured's age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

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

Renewal of Policy
If You do not cancel or change Your plan or if We have not been otherwise notified, Your Policy will automatically renew each year on January 1st at the new Premium amount. You will be notified of the new Premium amount prior to the renewal.

Section 14 – Definitions

Adverse Determination:

- Denial of a Prior Authorization for covered Benefits.
- Denial of a request for Benefits on the ground that the treatment or covered Benefit is not Medically Necessary, appropriate, effective, or efficient, or is not provided in or at the appropriate health care setting or level of care.
- Retroactive rescission or cancellation of coverage not attributable to failure to pay Premiums.
- Denial of excluded Benefits, when evidence is provided that there is a reasonable medical basis that the contractual exclusion doesn't apply, or
- Denial of a request for Benefits on the grounds that the treatment or service is Experimental or Investigational.

Allowed Amount - the amount that We will pay for Covered Health Services under this plan.

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

For Covered Health Services received from a Non-Network Provider at a Non-Network Facility and which have been Pre-Authorized by Us, Our Allowed Amount will be in accordance with Our reimbursement policies.

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

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

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

Ancillary Services- professional services, including surgery, anesthesiology, pathology, radiology, or hospital services and laboratory services.

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

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

Refer to the Schedule of Benefits 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 - (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

Brand Name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that is identified as a Brand Name product, based on available data resources including, but not limited to, Medispan, that classify

drugs as either Brand Name or Generic based on a number of factors. You should know that all products identified as “brand name” by the manufacturer, pharmacy, or Your Physician may not be classified as Brand Name by Us.

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

Child - means any of the following who are under the age of 26, regardless of residence in the same household as the Enrollee, the Subscriber or Dependent’s:

- Child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order
- Child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's Spouse
- Child placed for adoption
- Foster Child, including placement into foster care
- Legally adopted Child
- Natural Child
- Stepchild

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

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

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

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

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

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

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

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

Cosmetic Procedures - procedures or services that change or improve appearance without improving physiological function.

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

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

Crisis Stabilization Unit (CSU) – Where available, this is a level of care designed to de-escalate acute psychiatric/behavioral health and/or Substance Use Disorder symptoms. This treatment is typically 3 days or less, but may be longer when Medically Necessary and appropriate.

Custodial Care - services that are any of the following:

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

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

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

Domestic Partner – an individual of either the same or opposite sex living together in a committed domestic relationship but not joined in any type of legal partnership, marriage, or civil union legally recognized.

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

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

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

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

- Placing the mental or physical health of the Covered Person in serious jeopardy.
- Serious impairment to a bodily function.
- Serious dysfunction of any bodily organ or part.
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

Facility with use of a non-medical transportation or non-emergency medical transportation, if needed.

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

Exchange, also known as the Marketplace - is a transparent and competitive online insurance marketplace where individuals and small businesses can buy qualified health Benefit plans. The Exchange offers a choice of health plans that meet certain Benefits and cost standards.

Experimental, Investigational Service or Unproven Service(s) - medical, surgical, diagnostic, psychiatric, Substance Use Disorders 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
- 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, except when the member participates in an approved clinical trial, or
- 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
- 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
- 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,
- 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
- Part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity or efficacy of the Service.

Facility – an institution providing health care related services or a health care setting, including but not limited to an inpatient or outpatient Hospital, skilled nursing center, residential treatment center, diagnostic, laboratory and imaging center, rehabilitation and other therapeutic health settings, or freestanding surgical institution.

Family Annual Deductible – this is the most that a Family of two (2) or more enrollees would pay per calendar year towards their Deductible. No individual pays more than the individual Deductible amount.

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

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

Habilitative Services - health care services that help a person acquire, keep, or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. These services address the competencies and abilities needed for optimal functioning in interaction

with their environments. Examples include therapy for a Child who isn't walking or talking at the expected age. Adults, particularly those with intellectual disabilities or disorders such as cerebral palsy, can also Benefit from Habilitative Services. Habilitative Services include physical therapy, occupational therapy, speech-language pathology, audiology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

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

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

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

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

- Eosinophilic disorders as evidenced by the results of a biopsy.
- Glutaric acidemia.
- Histidinemia.
- Homocystinuria.
- Hyperlysinemia.
- Immunoglobulin E and non-immunoglobulin E-mediated allergies to multiple food proteins.
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.
- Maple syrup urine disease.
- Maternal phenylketonuria in female Covered Persons of childbearing age.
- Methylmalonic acidemia.
- Phenylketonuria in Covered Persons.
- Propionic acidemia.
- Severe food protein induced enterocolitis syndrome.
- Tyrosinemia.
- Urea cycle disorders.

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

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

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

Intermediate Care - Mental Health and Substance Use Disorder treatment that must be provided in a Hospital or treatment facility that is licensed to provide a continuous, structured program of treatment and rehabilitation, including 24-hour per day nursing care.

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

- Fewer than seven days each week; or

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

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

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

Medical Foods - prescription metabolic formulas and their modular counterparts that are:

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

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

Medically Necessary– services that a Medical Doctor (MD), Doctor of Osteopathy (DO), or similarly trained professional) or Provider would provide to a person in their care for the purpose of evaluating, diagnosing or treating an illness, Injury or disease, or associated symptoms, while exercising prudent clinical judgment such as:

- Generally accepted standards of medical practice in the United States;
- Specificity of clinical appropriateness unique to individual or circumstance (type, frequency and dosage of proposed intervention);
- Knowledge of scientifically established effectiveness of treatment

Generally accepted standards of medical practice shall reflect:

- Evidence-based guidelines;
- Clinical guidelines established by Physician specialty societies;
- Services are performed in the least costly setting and not only for the convenience of the patient or the physician.

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

Mental Health Disorder or Mental Illness – Conditions as described in the current *Diagnostic and Statistical Manual* of the American Psychiatric Association, including but not limited to: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder, trauma and stressor related disorders or post-traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, anorexia nervosa, bulimia nervosa, anxiety disorders, neurodevelopmental disorders, or other intellectual disabilities. 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.

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.

Network Pharmacy - a pharmacy that has:

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

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

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

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

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

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

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

Off-Label Use – A Prescription Drug Product approved by the FDA, which is prescribed for a use that is different from the use for which it is approved by the FDA. To qualify for Off-Label Use, the drug must be recognized for the specific treatment for which the drug is being prescribed by one of the following: (1) *U.S. Pharmacopoeia Dispensing Information;* (2) *American Medical Association's Drug Evaluations;* (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.

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

Out-of-Pocket Maximum - the maximum amount of Deductible, Coinsurance, or Copayments You pay every calendar year. Refer to the Schedule of Benefits to determine whether or not Your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization - means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

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 or Provider- any Doctor of Medicine, chiropractor, optometrist, optician, professional counselor, psychologist, clinical social worker, podiatrist, physical therapist, chiropodist, clinical nurse specialist, audiologist, speech pathologist, certified nurse midwife or other nurse practitioner, marriage and family therapist, licensed acupuncturist or Doctor of Osteopathy who is properly licensed and qualified by law.

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

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

Policy - the entire agreement issued to the Subscriber that includes all of the following:

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

Post-Stabilization Care - the services provided after the treating physician determines that a patient’s emergency medical condition is clinically stable. These services are provided to maintain, improve, or resolve the patient’s condition.

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

Pregnancy - includes all of the following:

- Prenatal care
- Postnatal care
- Childbirth
- Any complications of Pregnancy

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

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

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

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

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

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

Qualifying Event/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 a person keep, restore, or improve skills and functioning for daily living and skills related to communication that have been lost or impaired because a person was sick, injured, or disabled. These services include physical therapy, occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. Services must involve goals to be reached in a reasonable period of time.

Remote Patient Monitoring Services - the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

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

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

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

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

Semi-Private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

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

Sickness - Physical disease, physical Illness, and Pregnancy.

Skilled Nursing Facility - Hospital or nursing Facility licensed and operated as required by law.

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

Spouse – Your legal Spouse, or Domestic Partner

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 Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and Substance Use 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* does not mean treatment of the disorder is a Covered Health Service.

Telemedicine - use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment, regardless of the originating site and whether the patient is accompanied by a health care provider at the time such services are provided. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.

Transition of Care - allows You to continue to receive services for specified medical and behavioral conditions for a defined period of time with doctors, Hospitals, and Providers who are Non-Network.

Urgent Care Center - a walk-in Facility focused on the delivery of ambulatory care and primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an ER visit. Urgent Care Centers are distinguished from similar ambulatory health care centers such as Emergency departments and convenient care clinics by their scope of conditions treated and available facilities on-site.

Usual, Customary and Reasonable Charge - is the reasonable median rate paid for similar health care services within the surrounding geographic area in which the services were rendered. The surrounding geographic area may be determined by the type of service and the access to that service in the geographic region.