Bright HealthCare™

2022
Certificate of Coverage

BrightHealthCare.com

Section 1 - Title Page (Cover Page)
Individual Policy

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

This is a Network-Only Plan. This plan uses a network of Participating Providers to provide benefits to You. That means this Plan does not provide benefits for services You receive from Non-Network Providers except as described in Section 5 - How to Access Your Services and Obtain Approval of Benefits.

ENTIRE CONTRACT

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

- Schedule of Benefits
- Enrollment Application

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

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

HOW TO USE THIS DOCUMENT

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

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

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

TEN DAY RIGHT TO RETURN POLICY

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

Important Cancellation Information – Please read Section 11 -Termination/Nonrenewal/ Continuation found on page 82 of the policy.

INFORMATION ABOUT DEFINED TERMS

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

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

BRIGHT HEALTHCARE

Simeon Schindelman, Chief Executive Officer

Section 2 - Contact Us

Please contact Us for more information.

Questions About Your Benefits

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

On Our Website at:
www.brighthealthcare.com

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

Bright HealthCare
P.O. Box 16275
Reading, PA 19612

NONDISCRIMINATION NOTICE AND ASSISTANCE WITH COMMUNICATION

Bright HealthCare 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 HealthCare” means Bright Health Group and their affiliates, which are listed below.

Language Assistance and Alternate Formats:
Assistance is available *at no cost* to help You communicate with Us. The services include, but is not limited to:

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

To ask for help with these services, please call Customer Service at the number listed above or on Your 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 HealthCare Civil Rights Coordinator
P.O. Box 16275
Reading, PA 19612-6275
Phone: (844) 202-2154
Email: OAG@brighthealthplan.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. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

If You need help with Your complaint, please call the Customer Services number on Your member ID card. You must send the complaint within 60 days of discovering the issue.

Language Assistance and Alternate Formats
If You or someone You’re helping has questions about Bright HealthCare, You have the right to get help and information in Your language, at no cost. To ask for another format, please call Customer Service at the number listed above or on Your ID Card.

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 אי־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. Koji' 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 በሚገኘ የአባላት አገልግሎት ቁጥር ላይ ይደውሉ፡፡
Burmese	သင်သည် အင်္ဂလိပ်စကားမဟုတ်သော အခြားဘာသာစကားတစ်ခုအား ပြောဆိုသူဖြစ်ပါက ဘာသာစကားအခမဲ့ပံ့ပိုးသည့် ဝန်ဆောင်မှုအား သင်ရရှိနိုင်ပါသည်။ သင့် ID (သက်သေခံ) ကတ်ပြားပေါ်ရှိ အဖွဲ့ဝင်များဝန်ဆောင်မှုဌာနအား ဖုန်းခေါ်ဆိုပါ။
Cherokee	ᏧᏬᏎᏯᏓ: ᏐᎢ ᏎᏛᏂᏯᏩ ᏜᏛᏂᏧ ᏏᏃ ᎩᏢᏏ, ᏎᏛᏂᏜᏯᏗ ᎠᏢᏯᏚᏢᏯᏩ ᎢᏗᏓᎾᏗᏗᎢ, Ꮭ ᎪᎱᏯᏗ ᏧᎬᎶᏗ ᏜᎩ ᎠᏎᏇᎢ, ᏂᎯ ᏒᎶᏈᏲᎢᏯᏓᏩᏨᎢ. ᎾᏯᎩᏃ ᏨᏬᎾ ᏰᏢ ᎠᏢᏯᏚᏢᏯᏩ ᏗᏎᏯᏗ ᎤᎾᎢ ᏣᏤᏢ ᎠᏟᏯᏘᏗ ᏆᎾᏲᏯᏗ.
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 નિઃશુલ્ક 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 मुफ़्त 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	တ်ိနိၣ် – နမ့်ကတိၤကျိာ်လၢတမ့်အဲကလံးကျိာ်ဘၣ်နၣ်, ကျိာ်တၢ်တိစၢမၤစၢၤတၢ်မၤစၢၤတဖၣ်, လၢတလိၣ်ဟ့ၣ်အပ့ၢ်တဖၣ်အိၣ်လၢနဂီၢ်နၣ်လီၤ. ကိးကရၢဖိတၢ်မၤစၢၤတဖၣ် (နနၣ်ဘနမ့နမလၢစ္ဆ) အနီၣ်ဂံၢ်ဖဲန တၢ်အှၣ်သးနီၣ်ဂံၢ်ခးကုအဖိခိၣ်နၣ်တက့ၢ်.
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 بەخۆڕایی 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 ܕܡܡܠܠܝܬܘܢ ܐܝܠܝ ܠܫܢܐ ܐܚܪܢܐ ܣܛܪ ܡܢ ܠܫܢܐ ܐܢܓܠܝܙܝܐ، ܗܘ ܐ̈ܠܟܘܢ ܚܠܡܬܐ ܕܡܥܘܕܪܢܘܬܐ ܕܠܫܢܐ ܡܓܢܐܝܬ. ܠܐ ܡܨܝܬܘܢ ܩܪܘܢ ܡܢܝܢܐ ܕܚܠܡܬܐ ܕܗܕܡ̈ܐ (Member Services) ܕܟܬܝܒܐ ܥܠ ܟܪܛܝܣ ܗܝܝܘܬܟܘܢ.
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 Provider, 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 for services that are not covered by Your plan.
- Voice Your opinions, concerns, or complaints to Our *Customer Service* and/or Your health care professional.

- Notify Us and treating health care professional as soon as possible about any changes in family size, address, phone number or status with Your health benefit plan.

Section 3 - Table of Contents

Section 4 - Eligibility

We offer two types of Individual policies:
1. Individual Policies that cover at least one adult age 19 or older. This type of Policy may also include coverage for eligible Dependents.
2. Individual Child-Only Policies that cover children under age 21. This type of Policy does not have a parent or legal guardian enrolling in the Plan.

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

WHO IS ELIGIBLE FOR COVERAGE

Eligible Subscribers

To be eligible to enroll as a Subscriber under this Plan, You must:
- Reside in the Service Area; and
- Not be enrolled in Medicare 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, *except in the case of a child-only Policy*, that resides within the Service Area and meets the criteria of Spouse as stated in the *Definitions section of this Policy*.
- Your Child(ren) as defined in the *Definitions section of this Policy*.

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

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

WHEN COVERAGE BEGINS

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

OPEN ENROLLMENT PERIOD

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

SPECIAL ENROLLMENT PERIOD

Individuals who experience certain Qualifying Life Events can enroll in, or change enrollment within sixty (60) days of the Qualifying Life Event. For certain triggering events, such as loss of minimum essential coverage, or becoming newly eligible or ineligible for federal subsidy programs, an individual has sixty (60) days before and after the event to select a plan. The effective date of coverage depends on the qualifying events.

ENROLLING ELIGIBLE DEPENDENTS

Dependents who have a Qualifying Life Event as defined by state and federal law may be enrolled during a special enrollment period as described below. A special enrollment period is a period of time when enrollment is allowed before or after a person becomes eligible for coverage.

Dependents who are notified or become aware of the Qualifying Life Event may enroll during the sixty (60) calendar days before or after the effective date of the Qualifying Life Event. Coverage will begin no earlier than the day the Qualifying Life Event occurs.

Qualifying Life Events include:

- An individual involuntarily loses existing creditable coverage for any reason other than fraud, misrepresentation, or failure to pay a Premium;
- An individual gains a Dependent or becomes a Dependent through marriage, civil union, birth, adoption, or placement for adoption, placement for foster care, or by entering into a Designated Beneficiary agreement;
- A court orders that You cover a current spouse or minor child onto Your policy;
- The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by state law, or if the Enrollee, or his or her dependent, dies;
- An individual's enrollment or non-enrollment in a health benefit plan is unintentional, inadvertent, or erroneous and is the result of an error, misrepresentation, or inaction of the carrier, producer, or Exchange;
- An individual adequately demonstrates to the commissioner that the health benefit plan in which the individual is enrolled has substantially violated a material provision of its contract in relation to the individual;
- The Exchange determines an individual to be newly eligible or newly ineligible for the federal advance payment tax credit or cost-sharing reductions available through the Exchange pursuant to federal law;
- An individual gains access to other creditable coverage as a result of a permanent change of residence; or
- A parent or legal guardian disenrolling a Dependent, or a Dependent becoming ineligible for Medicaid or an S-CHIP plan;
- An individual becoming ineligible under the North Carolina Medicaid Program;
- An individual, who was not previously a citizen, a national, or a lawfully present individual, gains such status;
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An individual demonstrates to the Exchange, in accordance with guidelines issued by the US Department of Health and Human Services, that the individual meets other exceptional circumstances as the Exchange may provide;
- An individual or enrollee:
  - is a victim of domestic abuse or spousal abandonment, including a Dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or
  - is a Dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;
- An individual or dependent:
  - applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event; or
  - applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;
- An individual or Dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the decision to purchase a plan through the Exchange; or
- At the option of the Exchange, the individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Exchange following termination of Exchange enrollment due to a failure to verify such status within a specified time period or is under 100 percent of the Federal poverty level and did not enroll in coverage while waiting for verification of citizenship, status as a national, or lawful presence.
- Any other event or circumstance occurs as set forth in rules from the North Carolina Department of Insurance that defines triggering events.

If You know that a qualifying event is going to occur, You may apply for coverage during the sixty (60) calendar days prior to the effective date of the qualifying event.

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

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

A newborn dependent child of the Subscriber is automatically covered for the first 30 days of life. If You wish to continue enrollment of the newborn beyond the 31st day, You must enroll the newborn within 31 days of the date of birth. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber is required to pay the full Premium responsibility for the newborn within 31 days of the date of birth. Newborn Premiums are not pro-rated.

For newly adopted children (including children newly placed for adoption) and foster children, the effective date of coverage is the date of the adoption or placement for adoption, or the placement for foster care. An eligible adopted child must be enrolled within 30 days from the date the child is placed in Your custody or the date of the final decree of adoption. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber is required to pay the full Premium responsibility for the adopted child within 30 days of the adoption or placement for adoption. The monthly Premium for the newly adopted child is the entire month's Premium. Adopted child Premiums are not pro-rated.

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

If a Dependents is not enrolled when they first become eligible, the Dependent must wait until the next open enrollment period to enroll unless they enroll under the provisions described in the special enrollment period section described above.

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

- Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions, and limitations of the policy;
- Accept claim forms and requests for claim payment from the custodial parent; and
- Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge Our obligations.

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

CHANGE IN STATUS – NOTICE REQUIRED

The Subscriber is responsible for notifying Us or the Exchange of any changes that affect eligibility for services under this Policy. Changes may be on the Subscriber's or enrolled Dependent's eligibility. The Subscriber must notify Us or the Exchange within 60 days of the event. This includes changes of address, addition or deletion of

dependents resulting from death, achieving the limiting age, and changes in Dependent Disability or Dependent status. Coverage for ineligible members will terminate in accordance with the termination provisions described in this Policy.

Section 5 - How to Access Your Services and Obtain Approval of Benefits

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

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

THIS IS A NETWORK-ONLY PLAN

This plan uses a Network of Participating Providers to provide benefits to You. That means this Plan does not provide benefits for services You receive from Non-Network Providers, unless:

- You have a medical emergency;
- You are treated by a Non-Network Provider when You are receiving care at a Network Facility; or
- We authorize services out-of-network because the Medically Necessary services that You need are not available from a Participating Provider.

You can review Our provider network online at www.brighthealthcare.com, or You can contact the *Customer Service* Department at the telephone number listed in *Section 2* 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 Physician 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 *Section 2* 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 and are solely responsible for the care they deliver.

Before obtaining services, You should always verify whether or not 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 Section 2 of this Policy and on Your ID card.

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

Our provider network includes a sufficient number of essential community providers (ECPs) within Our geographic service area, where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in health professional shortage areas. Our provider network complies with 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 Pre-Authorization from the plan or from any other person (including a primary care provider) in order to obtain access to mental health, obstetrical, or gynecological care from a health care professional in Our network who specializes in those types of services. The health care professional, however, may be required to comply with certain provisions related to 1) obtaining Pre-Authorization 2) following a pre-approved treatment plan, and 3) following procedures for making referrals to other Participating Providers. For a list of participating health care professionals who specialize in eye care, mental health, and obstetrics or gynecology, visit Our website at www.brighthealthcare.com or call Our Customer Service line at the number listed in Section 2 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 specific medical and behavioral care for a defined period of time with doctors, hospitals, and Providers who are not in Our Network until the safe transfer of care to a Network Provider can be arranged.

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

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

- Pregnancy, in the second 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 who are less than six months post-transplant.
- End-stage renal disease and dialysis.
- a life-threatening disease or condition.

If You have entered the second trimester of pregnancy on the date You received notice of the Provider’s termination, and the provider was treating the pregnancy before the date of the notice or the date of enrollment in the new plan, You are eligible for Continuity of Care with respect to the Provider's treatment of the pregnancy through the pregnancy and for 60 days of postpartum care. This section does not apply to treatment by a Provider or Provider group whose contract with Us has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity

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

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

For information on how to apply for Transition of Care, contact 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 45 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 and subject to the Provider's agreement, for continuation of Covered Health Services rendered by the terminated Provider for the time periods shown below. Co-payments, Deductibles or other cost sharing components will be the same as You would have paid for a Provider currently contracting with Us.

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

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

Pregnancy – If You have entered the second trimester of pregnancy on the date You received notice of the Provider's termination, and the provider was treating the pregnancy before the date of the notice or the date of enrollment in the new plan, You are eligible for Continuity of Care with respect to the Provider's treatment of the pregnancy through the pregnancy and for 60 days of postpartum care. This section does not apply to treatment by a Provider or Provider group whose contract with Us has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract with Us to provide only certain Covered Health Services, but not all Covered Health Services.

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 the Customer Service Department at the telephone number listed in Section 2 of this Policy and on Your ID card. The provider's Network status is subject to change, so always confirm the provider's Network status with the provider at the time services are received.

ACCESS PLAN

We have prepared and maintain a Network Access Plan that describes how We monitor the Network of providers to ensure that You have access to care. The Network access plan is maintained at Our offices. Please contact Customer Service at the telephone number listed in *Section 2* of this Policy and on Your ID card if You wish to review these policies.

DESIGNATED FACILITIES AND OTHER PROVIDERS

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

In most cases, non-emergent care received from a Non-Network Provider is not covered.

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.

If you need Medically Necessary care that cannot be provided by a Network Provider, You will not be charged additional expenses because use of a Non-Network Provider is required. The care must be Prior-authorized. You will be responsible for Copayment, Deductible and Coinsurance amounts as if You had 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 Medical Conditions and You did not have Pre-Authorization from Us, the services will not be covered. You will be responsible for the entire amount that the Provider bills.

REFERRALS TO SPECIALISTS

You must obtain a Referral from Your Primary Care Physician before visiting a Specialist Provider. A referral authorizes a specific number of visits that You can make to a Specialist Provider within a designated time frame. If you receive treatment from a Specialist Provider without a Referral from you Primary Care Physician, the treatment will not be covered.

Referrals are not required to see certain eye care providers, mental health care providers, pediatricians, obstetrical or gynecological health care professionals

STANDING REFERRAL TO SPECIALIST

You may apply for a standing Referral to a Provider other than your PCP when all of the following conditions apply:

- You are a covered Member of a Bright Health Individual Plan;
- You have a disease or condition that is life threatening, degenerative, chronic or disabling;
- Your Primary Care Physician in conjunction with a Network Specialist determines that Your care requires another Provider’s expertise;
- Your PCP determines that Your disease or condition will require ongoing medical care for an extended period of time;

- The standing Referral is made by Your Primary Care Physician to a Network Specialist who will be responsible for providing and coordinating Your specialty care; and
- The Network Specialist is authorized by Us to provide the services under the standing Referral.

We may limit the number of visits and time period for which You may receive a standing Referral. A standing Referral may be effective for up to 12 months and may be renewed and re-renewed by Your Primary Care Physician. If You receive a standing Referral or any other Referral from Your Primary Care Physician, that Referral remains in effect even if the Primary Care Physician ceases to be a Participating Provider under the Plan. If the treating Specialist leaves Our network or You cease to be a covered Member, the standing Referral expires.

Standing Referrals to Non-Network Providers will be allowed when the care is not available from a Participating Network Provider. 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 authorize a standing Referral to see a Non-Network Provider. You will not be denied necessary medical care or charged additional expenses because use of a Non-Network Provider is required. 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.

RECEIVING EMERGENCY CARE FROM NETWORK PROVIDERS OR NETWORK FACILITIES

When receiving Medically Necessary Emergency Health Services from a Participating or In-Network facility, You will be responsible for Your In-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, unless otherwise permitted by law, will be the greater of :

- The median amount negotiated with In-Network Providers for the emergency service;
- Usual, Customary and reasonable rate based on the geographic region; or
- The amount that would be paid under original Medicare fee-for-service 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.

PRE-AUTHORIZED CARE FROM NON-NETWORK PROVIDERS

In a case where We do not have a Participating Provider or specialist within the network to provide services for a covered benefit, We may issue Pre-authorization to see a non-network provider.

If you need Medically Necessary care that cannot be provided by a Network Provider, You will not be charged additional expenses because use of a Non-Network Provider is required. The care must be Prior-authorized. You will be responsible for Copayment, Deductible and Coinsurance amounts as if You had received services from a Network Provider.

PAYMENT TO NON-NETWORK PROVIDERS

Refer to the Section 5, Receiving Non-Emergent Care From Non-Network Providers for situations in which We would cover services to Non-Network Providers.

If You receive care from a Non-Network Provider, You may be required to pay the charges in full to that Provider at the time of service. To be 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:

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

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

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

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 original Medicare fee-for-service.
- As Usual, Customary and Reasonable reimbursement terms established.
- 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 any balances other than Your Copayment, Deductible or Coinsurance amounts after the Provider receives payment from Us.

Services provided by a Non-Network Provider at a Network facility will be reimbursed according to Our Network reimbursement policies. You will be not be responsible for any payments beyond Your Copayment, Deductible and Coinsurance amounts, which will be at the same rate as if the services had been provided by 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 considered as Non-Network Benefits.

SERVICE AREA

Your Service Area is an area where Network Covered Health Services are generally available and readily accessible to You and Your covered Dependents.

Services from Network Providers can be accessed anywhere in Your Service Area. Any services received outside of Your Service Area from a Non-Network Provider will be considered Non-Network, 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 Pre-Authorization from Us.

Please refer to the provider directory on Our website at ***www.brighthealthcare.com*** for a list of Network Providers in Your Service Area. You can also contact *Customer Service* at the telephone number listed in Section 2 of this Policy and on Your ID card for assistance.

MEDICAL NECESSITY

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

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

PRE-AUTHORIZATION

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

Who is responsible for obtaining Pre-Authorization?
If You are receiving care from a Network Provider, the Provider is responsible for obtaining Pre-Authorization before they provide these services to you. If the Provider fails to obtain Pre-Authorization and the service is denied, the Provider may not bill You for those services.

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

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

- 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 Your health care choices.

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

Standard Prior Authorization Process
The Pre-Authorization review process requires the full cooperation of the requesting Physician in order for Us to evaluate all of the pertinent information and make a coverage determination. Pertinent information includes the results of any patient examination, clinical evaluation, or second opinion that may be required.

Prospective and Concurrent Pre-Authorization Review
Prospective and concurrent Pre-Authorization determinations shall be communicated to Your Provider within three (3) business days after We receive all necessary information about the admission, procedure, or health care service. If We authorize a health care service, We shall notify the Your Provider. For an Adverse Determination or Denial of the Pre-Authorization request, We shall notify Your Provider and send written or electronic confirmation of the Denial to You. For concurrent reviews, We shall remain liable for health care services until You have been notified of the Adverse Determination.

We must make Our determination within 15 calendar days of receiving the Pre-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 determination. If Your request to expedite is granted, We must give You a decision within 72 hours after We get the supporting statement from Your Physician. The timeframe for making a coverage determination may be extended if the Pre-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).

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

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

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

REQUESTS FOR RETROSPECTIVE PRIOR AUTHORIZATION OF SERVICES MORE THAN 180 DAYS AFTER THE DATE OF SERVICE WILL BE DENIED.

UTILIZATION MANAGEMENT
When We receive a request for Pre-Authorization of health care services We may work with 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 who are trained to assess the clinical information used to support Care Management decisions. Our decision-making is based only on appropriateness of care and the existence of coverage. 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 Medical Necessity, 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 identification (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 otherwise owed to You. The billing address used is based on the plan

under which Your coverage is issued; therefore, it is important that You verify that Your provider has the correct billing information on file for Your plan.

MEMBER COST SHARING REQUIREMENTS

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

Refer to Your Schedule of Benefits for Coinsurance Percentage and other limitations.
The amount provided or payable will be subject to:

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

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

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

Annual Deductibles are the amount You must pay towards any Allowed Amounts for Covered Health Services incurred in a calendar year before We will begin paying for Benefits. 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 charge 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 In-Network Covered Health Services will apply to the Out-of-Pocket Maximum. 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 Covered 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 In-Network Covered Health Services for the remainder of the Calendar Year. Once two (2) or more Covered Persons' 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 In-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 that any of the individual termination conditions listed in the *Termination/Nonrenewal/Continuation* S*ection of this Policy*
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in this Policy.

This section describes Covered Health Services for which Coverage is available. Please refer to the *Schedule of Benefits (Who Pays What) section of this Policy* for details about:

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

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

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

LISTING OF COVERED HEALTH SERVICES

Please refer to *Section 5 - How to Access Your Services and Obtain Approval of Benefits* to determine whether the services require Pre-Authorization.

Accident Related Dental Services

Outpatient Services, physician Home Visits and Office Services, care for Emergency Medical Conditions and Urgent Care services received for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient’s condition. “Initial” dental work to repair injuries due to an accident means services are requested within 60 days from the onset of injury and are performed within 6 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

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

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

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

Non-Emergency ambulance transportation by a licensed ambulance service (either ground, air or water ambulance) is covered between facilities **only** when the transport is one of the following:
- Transfer from a Non-Network Hospital/facility to a Network Hospital/facility.
- Transfer to a Hospital that provides a higher level of care than was available at the original Hospital/facility.
- Transfer to a more cost-effective acute care facility.
- Transfer from an acute facility to a sub-acute facility/setting.

Non-emergent air transportation requires Pre-Authorization.

Autism Spectrum Disorders (ASD)
Covered Health Services under this section include coverage for the assessment, diagnosis, and treatment of Autism Spectrum Disorder. Treatment covered includes:
- Evaluation and assessment services;
- Behavior training and management, including but not limited to consultations, direct care, supervision, or treatment, or any combination thereof, provided by autism services providers;
- Habilitative or rehabilitative care, including, but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies.
- Psychiatric care;
- Psychological care, including family counseling;
- Pharmacy and medication as covered under the terms of this Policy.
- Therapeutic care, which includes behavioral analysis; Habilitative or Rehabilitative Services.

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

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

Blood
Covered Health Services under this benefit include the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storying Your own blood only when it is stored and used for a previously scheduled procedure.

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

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

Chemotherapy Services - Outpatient
This Plan will cover intravenous chemotherapy treatment received on an outpatient basis at a Hospital or Alternate Facility.

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

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

Benefits under this section include:

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

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

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

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

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

Clinical Trials
Covered Health Services under this section include routine patient care costs during a clinical trial if:

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

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

The coverage does not include:
- Any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;
- Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
- 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; or
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the Covered Person's health plan;
- 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) The National Institutes of Health.
  (ii) The Centers for Disease Control and Prevention.
  (iii) The Agency for Health Care Research and Quality.
  (iv) The Centers for Medicare & Medicaid Services.
  (v) cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.
  (vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  (vii) A study or investigation has been conducted and approved through a system of peer review by one of the following:
    (I) The Department of Veterans Affairs.
    (II) The Department of Defense.
    (III) The Department of Energy.

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

and Drug Administration.
(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
(E) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as any non-investigational alternative.

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

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 Defect 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.

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

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

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.

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

- Outpatient self-management training, education, and medical nutrition therapy services ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.
- Medical eye examinations (dilated retinal examinations) for Covered Persons with diabetes
- Preventive foot care for Covered Persons with diabetes.
- Podiatric appliances for prevention of complications associated with diabetes; foot orthotic devices and inserts (therapeutic shoes: including Depth shoes or Custom Molded shoes.) Custom molded shoes will only be covered when the member has a foot deformity that cannot be accommodated by a depth shoe. Therapeutic shoes are covered only for diabetes mellitus and *any* of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation.
- Elastic stockings.
- Insulin pumps and supplies used conjunction with the insulin pumps.

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

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.

Note: *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 Surgery – Outpatient provision of the Benefits/Coverages (What is Covered) section of this Policy. Examples of surgical imaging procedures include arthroscopy, laparoscopy, bronchoscopy, and hysteroscopy*.

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

Dialysis Services - Outpatient
This Plan covers dialysis treatments received on an outpatient basis. Dialysis may be received at a Hospital or Alternate Facility.

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

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

Benefits under this section include:

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

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

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

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

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

If more than one piece of Durable Medical Equipment can meet Your functional needs, Coverage is available only for the equipment that meets the minimum specifications for Your needs. Coverage is for medically appropriate equipment only, and does not include special features, upgrades or equipment accessories.

With some Durable Medical Equipment items, We will authorize a rental instead of a purchase. The decision is based on the length of need, the cost of the item and the frequency of servicing. When Durable Medical Equipment is rented, benefits cannot exceed Our Allowable Amount to purchase the equipment. If You rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, You will be responsible for any cost difference between the piece You rent or purchase and the piece We have determined is the most cost-effective.

Examples of Durable Medical Equipment include but are not limited to:
- Equipment to assist mobility, such as a standard wheelchair
- A standard Hospital-type bed
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors, and masks).
- Delivery pumps for tube feedings
- Urinary catheters and associated equipment
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Nebulizers and Peak Flow Meters. Coverage under this plan includes the purchase of one (1) nebulizer in a calendar year period, or one (1) rental per episode, and the purchase of (1) peak flow meter. We will determine if the nebulizer is purchased or rented. Charges are covered at 100% of the Allowed Amount and are not subject to the Annual Deductible, Copayment, or Coinsurance.

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

Coverage is available for repairs and replacement, except that:
- Coverage for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect. Established guidelines by Medicare are followed for the lifetime of DME. Equipment is expected to last at least five (5) years.
- Coverage is not available to replace lost items.

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

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

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

Emergency Medical Conditions
Covered Health Services under this section include services required to stabilize Your condition in an Emergency situation.

Benefits under this section include the facility charge, supplies, and all professional services required to stabilize Your condition and/or initiate treatment. This includes:

- Professional Services including services rendered by the Emergency room Physicians, consulting Physicians, pathologists, radiologists, and anesthesiologists.
- Placement in an observation bed or a Crisis Stabilization Unit for the purpose of reducing the severity of Your Mental Health and/or Substance Abuse 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 department, You, Your Physician or Hospital must notify Us within 24 hours, or as soon as reasonably possible.

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

Care and services provided in an emergency room for non-emergent conditions may not be covered (for example, emergency room care for a prescription refill in a non-emergent situation or routine treatment of an infection).

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

Family Planning Services
Family Planning Services covered under the Plan include:

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

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

Gender Identity & Gender Transition Services
Covered preventive health services under this plan are available based on medical appropriateness without limitation to stated gender.

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

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 includes charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease.
Genetic testing is covered only if:

- The Covered Person has symptoms or signs of a genetically-linked inheritable disease;

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

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

Pre-Authorization is required for Genetic Testing services.

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

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

For Covered Persons under the age of 22, coverage also includes one hearing aid per hearing impaired ear every thirty-six (36) months. Hearing loss must be verified by a licensed Physician or by an audiologist. The hearing aids shall be medically appropriate to meet the needs of the member according to accepted professional standards. Coverage shall include the purchase of the following, limited to the least expensive professionally adequate device:
- Initial hearing aids and replacement hearing aids not more frequently than once per thirty-six (36) month period;
- A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the member;
- Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

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

High Tech Diagnostic Imaging, Nuclear Medicine, and Major Diagnostic Services – Outpatient
This Plan covers CT scans, PET scans, MRI, MRA, BEAM (Brain Electrical Activity Mapping) nuclear medicine, or major diagnostic services received on an outpatient basis at a Hospital, Alternate Facility.

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

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

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

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

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

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

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

Care must be received from a licensed hospice agency.

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

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

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

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

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

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

Immunizations
Covered immunizations for adults and children over age 2 include:
- Influenza, Trivalent inactivated influenza vaccine (TIV)
- Influenza, Live attenuated influenza vaccine (LAIV)
- Pneumococcal
- Hepatitis A (Hep A)
- Hepatitis B (Hep B)
- Td/Tdap (Tetanus, diphtheria, pertussis)

- Polio (IPV)
- Varicella (Var)
- Meningococcal Conjugate vaccine (MCV4)
- MMR (Measles, mumps, rubella)
- HPV Vaccine
- Shingles Vaccine
- DTap (Diphtheria, tetanus, pertussis)
- Other immunizations approved by the plan.

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

Immunizations are not subject to the annual routine visit limitation.

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

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

Infusion Therapy Services - Outpatient
This Plan covers intravenous infusion therapy treatment received on an outpatient basis at a Hospital or Alternate Facility.

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

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

Benefits under this section include:
The facility charge and the charge for related supplies and equipment. Physician services for anesthesiologists, pathologists, and radiologists.

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

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

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

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

Lab, X-Ray, and Diagnostic Services - Outpatient
This Plan covers laboratory, x-ray, and radiology services performed for a diagnosis. Services may be provided on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office.

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

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

Lymphedema
Covered Health Services under this section include equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be Medically Necessary and is provided by a licensed health care professional whose scope of practice includes the treatment of lymphedema.
Gradient compression garments for treatment of lymphedema are also covered. Gradient compression garments:
- Require a prescription;
- Are custom-fit for the covered individual; and
- Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products

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

Some Covered items may include:
- Ostomy Supplies
  - Pouches, face plates, and belts.
  - Irrigation sleeves, and bags.
  - Skin barriers
- Catheter Supplies
- Tubing and connectors for delivery pumps
- Burn garments
- Supplies related to insulin pumps

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

Mental Health and Substance Abuse Services
Covered Health Services under this section include treatment for Mental Health and Substance Abuse 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 covered under this Policy while a Covered Person is receiving Hospice Care.

Inpatient Care
Covered Health Services include inpatient hospitalization for Mental Health Disorders and for substance abuse services. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Intermediate Care
Intermediate Care services may include:
- Residential treatment.
- 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.

Outpatient
Covered outpatient services may include:
- Biofeedback
- Crisis intervention
- Diagnosis
- Medication management
- Mental health, Substance Abuse Disorder, and chemical dependency evaluations and assessment
- Outpatient Electroconvulsive Therapy (ECT)
- Outpatient Detoxification
- Referral services
- Short-term individual, family, and group therapeutic services
- Treatment planning

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

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 benefits than those on medical/surgical benefits.

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

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

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

- Pouches;
- Face plates and belts;
- Irrigation sleeves, bags and catheters;
- Skin barriers, gauze, adhesive, adhesive remover;
- Deodorant; and
- Pouch covers.

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

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

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.
- Topical fluoride application twice in a 12-month period where the local water supply is not fluoridated.
- Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

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

- Amalgam, composite restorations, and stainless-steel crowns.
- Dental examinations, visits, and consultations once within a six-month consecutive period (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 at 36-month intervals, bitewing x-rays at six-month intervals, and other x-rays if Medically Necessary (once primary teeth erupt).

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

Periodontics
This plan covers non-surgical periodontal services. 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.

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 up to 16 years of age.
- 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.

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

- Mobilization of erupted or malpositioned 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.

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

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

- 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.

Orthodontic treatment is covered only when Medically Necessary as evidenced by a handicapping malocclusion and when Pre-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 Vision Services
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.
The Enrolled Child may receive one routine eye exam per calendar year to determine the need for vision correction, including dilation if professionally indicated.

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

Lenses include:
- Single vision, bifocal, trifocal and lenticular;
- Choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses; and
- Scratch resistant coating.

Other optional lenses and treatments include:
- Ultraviolet Protective Coating
- Polycarbonate Lenses
- Blended Segment Lenses
- Standard Progressives
- Premium Progressives
- Photochromic Glass Lenses
- Plastic Photosensitive Lenses
- Polarized Lenses
- Standard Anti-Reflective Coating
- Ultra Anti-Reflective Coating
- Hi-Index Lenses

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

<u>Low Vision</u>
Services for low vision include:
- One (1) comprehensive low vision evaluation every five (5) years;

- Low vision aids;
- Up to four (4) follow-up care visits in any five (5) year period.

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

Pharmaceutical Products – Outpatient
This Plan covers Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

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

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

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

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

Care may be provided at a Physician's office, in a freestanding clinic, in a Hospital, at the patient's home, or provided as Telemedicine.

Coverage includes medical education services provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:
- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease, which requires the intervention of a trained health professional.

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

Clinic Fees
A Clinic Fee may be billed by a Provider when Physician's Office Services are received at an Outpatient Clinic that is owned by a hospital. Your Deductible and Coinsurance will apply to Clinic Fees and charges You pay will count towards Your Out-of-Pocket Maximum.

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

Positional Plagiocephaly
Covered Health Services under this section include orthotic devices for correction of Positional Plagiocephaly, including dynamic orthotic cranioplasty (DOC) bands and soft helmets. Devices are limited to one device per lifetime per member.

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 receive post-stabilization care that We have not authorized, care may not be covered.

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

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

We will pay Benefits for a stand-alone birthing center or for an inpatient Hospital stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

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

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

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

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

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

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

- Annual Deductibles, Copayments, Coinsurances, Days' Supply Limits, and other Quantity or Supply Limits.

- Eligibility at the time of service;
- Pharmacy filling Your prescription;

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

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

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

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

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

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

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

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 You less than medications not on the Formulary. The Formulary contains both Brand-Name and Generic medications.

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

You may view the Formulary at Our website www.brighthealthcare.com or contact the Pharmacy 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.

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

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

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

Pre-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 Pre-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.

Exceptions
Exceptions to above may be granted in certain circumstances or for emergency or special situations. Your prescriber or doctor and pharmacy staff will need to provide certain information in order for Us to review an exception

request. There is a process to appeal decisions. You received a copy of the appeals process with Your Policy. You will also receive the information if You are denied a claim.

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

- You can ask Your health care provider if there is another covered medication that will work for You.
- 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 are:

- Medication that is normally covered has caused a harmful reaction to You;
- There is a reason to believe the medication that is normally covered would cause a harmful reaction; or
- 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.

Drugs determined by Our Pharmacy & Therapeutics Committee to be deficient are excluded from the Formulary exceptions process.

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, call the Pharmacy Customer Services number on Your ID Card.

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

Off-label Cancer Medications

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

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

To qualify for Off-Label use, the drug must be recognized for the specific treatment for which the drug is being prescribed by one of the following four compendiums: (1) National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendia; (2) The Thomson Micromedex DrugDex, (3) The Elsevier Gold Standard's Clinical Pharmacology; or (4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services. A Prescription Drug Product includes a drug approved by the FDA prescribed to treat cancer during certain clinical trials as described in the Policy.

Oral Anticancer Medication

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

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

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

Your Prescription Drug benefit includes coverage for the following drug tiers:
Tier 1: Preventive Medications 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

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

Covered Medications and Products
Covered products are subject to deductibles, copayments and/or coinsurance, Formulary status, brand or generic status, Specialty Prescription status, and pharmacy network status, as well as other Days Supply Limits, or Quantity or Supply Limits defined in the Outpatient Prescription Medications Schedule of Benefits.

- Coverage is limited to prescription products, prescribed by a legal prescriber. Prescription Medications are labeled as “Caution: Federal Law Prohibits Dispensing without a Prescription” “Rx Only”, and/or where the State of North Carolina recognizes such products as requiring a prescription or mandates coverage as such.
- Insulin is covered as a prescription product, along with:
  - Cartridges including cartridges for the legally blind;
  - Medically Necessary injection aids;
  - Syringes and monitors for the visually impaired;
  - Lancets including automatic lancing devices
  - Glucose test strips;
  - Visual reading test strips;
  - Urine testing strips;
  - Glucagon;
  - Standard blood glucose monitors and Medically Necessary blood glucose monitors for the legally blind; and
  - Prescription Medications for controlling blood sugar (oral medications).

  For most plans, Your cost for a thirty (30) day supply of insulin will not exceed $100. If You are enrolled in an HSA or 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, and subject to the same deductibles, co-pays, and network providers as other prescription products, when used to treat PKU.
- Specialty Pharmaceutical medications, as defined by the plan when dispensed by Our Specialty Pharmacy Network Supplier.
- Contraceptives medications, devices, and various other products are covered for use as birth control.
- Immunizations administered at a Network Pharmacy.
- Medications prescribed to treat emergency medical conditions while traveling outside the United States.

We may limit the quantities of certain supplies to an amount considered to be reasonable for a thirty (30) day period. When quantities exceed what We consider reasonable for a given time frame, there must be an explanation of the

Medical Necessity for the quantities. If this information is not provided to Us, there may be a delay in processing the claim or the claim may be denied.

Prescription Drug Refill Limitations

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

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

Prescription Eye Drop Refills

Prescription eye drop refill renewals are allowed for a Covered Person if the refill is requested once 70% of the initial days' supply submitted by the pharmacy has been used. For example, after the first twenty-one days for a thirty-day supply of eye drops, forty-two days for a sixty-day supply of eye drops, or sixty-three days for a ninety-day supply of eye drops the last date that the prescription was filled. One additional bottle of prescription eye drops will be allowed if a bottle is requested by the Covered Person or Participating Provider at the time the original prescription is filled; and the original prescription states that one additional bottle is needed by the insured for use in a day care center, school, or adult day program. The additional bottle is limited to one bottle every three months.

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

Prescription eye drop refills are subject to the plan's annual Deductible, Copayment, or Coinsurance amounts.

Synchronization of Prescription Refills

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

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

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.

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

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

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:
- Pre-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 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 federal and state mandated preventive health care services.

Federally-Mandated Preventive Health Care Services
Federally mandated preventive health care includes 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.

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

Note: *If a Covered Person receives the same preventive screening more than once in a calendar year, the service will not be considered Preventive and the Plan's Lab, X-Ray and Diagnostics benefits will apply. Services will be subject to the Plan's Annual Deductible, Copayment, or Coinsurance.*

State Mandated Preventive Health Care Services
- Bone Mass Measurement Services - To qualify for coverage of this benefit, one or more of the following criteria must be satisfied:
  - An individual is estrogen-deficient and at clinical risk of osteoporosis or low bone mass;
  - An individual has radiographic osteopenia anywhere in the skeleton;
  - An individual is receiving long-term glucocorticoid (steroid) therapy;
  - An individual has primary hyperparathyroidism;
  - An individual is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;
  - An individual has a history of low-trauma fractures; or
  - An individual has other conditions or on medical therapies known to cause osteoporosis or low bone mass.
- Colorectal Screening - Colorectal cancer examinations and laboratory tests for cancer are covered for any symptomatic or asymptomatic **member** who is at least 50 years of age, or is less than 50 years of age and at high risk for colorectal cancer.
- Gynecological Exam and Cervical Cancer Screening - includes the examination and laboratory tests for early detection and screening of cervical cancer, and **a** Physician's interpretation of the lab results. Coverage for cervical cancer screening includes Pap smear screening, liquid-based cytology, and human papillomavirus detection, and will follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.
- Newborn Hearing Screening - Coverage is provided for newborn hearing screening ordered by a physician to determine the presence of permanent hearing loss.
- Ovarian Cancer Screening - For female **members** ages 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered. A person is considered "at risk" if they:
  - Have a family history with at least one first-degree relative with ovarian cancer; and a second relative, either first-degree or second-degree with breast, ovarian, or nonpolyposis colorectal cancer; or
  - Tested positive for a hereditary ovarian cancer syndrome.
- Prostate Screening - One prostate specific antigen (PSA) test or an equivalent serological test will be covered per Covered male per calendar year. More PSA tests will be covered if recommended by a Physician.
- Screening Mammograms - Coverage includes one baseline mammogram for any female member between the ages of 35 and 39. Beginning at age 40, one screening mammogram will be covered per female member per calendar year, along with a Physician's interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a Physician when female members are considered at risk for breast cancer. Female members are considered at risk if they:
  - Have a personal history of breast cancer

- Have a personal history of biopsy-proven benign breast disease
- Have a mother, sister, or daughter who has or has had breast cancer, or
- Have not given birth before the age of 30.

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

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

- Prosthetics will be covered in accordance with recommended guidelines and criteria.
- Bionic, myoelectric, microprocessor-controlled, and computerized Prosthetics are covered in accordance with Medicare guidelines and criteria.
- Artificial face, eyes, ears, noses, legs. Arms and terminal devices such as a hand or hook.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.
- Wigs for Covered Persons undergoing treatment for cancer or other conditions treated by chemotherapy or radiation. Limited to one (1) wig per calendar year up to $500.

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

The prosthetic device must be ordered or provided by, or under the direction of a Physician.
Coverage is available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse.
- There are no Benefits for replacement due to misuse or loss.

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

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

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

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

Benefits under this section include:

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

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

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

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

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses;
- Treatment of physical complications of the mastectomy, including lymphedema;
- At least two postoperative prosthesis subject to the terms and conditions of this policy.

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

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

These Benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical Benefits provided under this Plan. (See the "Schedule of Benefits (Who Pays What)" for details.) If You would like more information on WHCRA Benefits, call Us at the number listed in Section 2 of this Policy or on the back of Your Identification Card.

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

- Physical therapy
- Occupational therapy
- Chiropractic Manipulations

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

Please refer to *Section 7 – Limitations/Exclusions* to see services that are excluded from Chiropractic Care.

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

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

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

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

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

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

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

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

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

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

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

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

Sleep Studies
Covered Health Services under this section include sleep studies and related services when performed at home including auto-titration, as well as when performed in a Hospital or Alternate Facility. Sleep studies are covered when Medically Necessary. These charges include Physician services, interpretation of the sleep study, and the sleep lab.

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

Benefits under this section include certain procedures such as arthroscopy, laparoscopy, bronchoscopy, and hysteroscopy.

Benefits under this section include the facility charge and the charge for supplies and equipment and Physician

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

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

Covered Health Services include diagnosis and treatment of TMJ that is recognized by the medical or dental profession as effective and appropriate for TMJ including splinting, intraoral prosthetic appliances used to reposition the bones, or any other Medically Necessary procedures involving any bone or joint of the jaw or face.

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

Transplantation Services
Covered Health Services under this section include organ and tissue transplants when ordered by a Physician. Coverage is available for transplants when the transplant meets the definition of a Covered Health Service and is not an Experimental, Investigational, or Unproven Service. All transplants must be performed at a plan-designated Centers of Excellence facility.

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

Transplant Benefit expenses include services related to donor search and acceptability testing of potential live donors. Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under this Policy.

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

Travel Expenses
Covered Services under this benefit include reimbursement for travel expenses primarily related to Transplantation Services, including meals and lodging when it is necessary for a Covered Person to receive care from a designated Centers of Excellence facility.

Organ transplant travel benefits are not available for cornea transplants.

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

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

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

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

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

In addition to the recipient being covered for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany the recipient. The term companion includes Your spouse, a member of Your family, Your legal guardian, or any person not related to You, but actively involved as Your caregiver.

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

Travel Expenses require Pre-Authorization from the plan. If You need assistance with reimbursement for travel expenses, contact Customer Service at (855) 827-4448.

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

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

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

BENEFIT LIMITATIONS

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

BENEFIT EXCLUSIONS

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

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

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

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

Alternative Health Care Treatments

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

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

Chiropractic Care

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

- CT scans, MRIs, x-rays and laboratory services which are not within his or her scope of practice, as defined by state law.
- Charges for care not provided in an office setting.
- Manipulation under anesthesia.
- Maintenance or preventive treatment consisting of routine, long term or Non-Medically
- Appropriate care provided to prevent reoccurrences or to maintain the patient’s current status.
- Vitamin or supplement therapy.
- Supplies ordered by a chiropractor.
- Infusion therapy or chelation therapy.

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

Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting and taking medicine, except as stated in the What is Covered section of this Policy.

Dental Care
Dental care is not covered, except as defined under Section 6, Pediatric Dental Care.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:
- Transplant preparation;
- Prior to the initiation of immunosuppressive medications; and
- The direct treatment of cancer or cleft lip or cleft palate.

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

Endodontics, periodontal surgery and restorative treatment are not covered, except as defined under Section 6, Pediatric Dental Care.

Preventive care, diagnosis and treatment of or related to the teeth, jawbone and gums are not covered, except as defined under Section 6, Pediatric Dental Care. Examples include:
- Extraction, restoration and replacement of teeth;
- Medical or surgical treatments of dental conditions; and
- Services to improve dental clinical outcomes.

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

Dental braces (orthodontics) are not covered, except as defined under Section 6, Pediatric Dental Care, or when Medically Necessary.

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

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

This exclusion does not apply to dental services required for the direct treatment of a medical condition such as treatment for cleft lip or cleft palate for which Benefits are described in Section 6; or for accident-related dental services received within 6 months from the date of the accident or injury. Dental services received more than 6 months after the accident or injury are not covered.

Devices, Appliances
Health care services that are not covered by the Plan, even if prescribed by a Physician are:
- Devices used specifically as safety items or to affect sports performance;
- Orthotic appliances that straighten or re-shape a body part except for Positional Plagiocephaly, such as foot orthotics (except for diabetic shoes), cranial banding and some types of braces, including over-the-counter orthotic braces;
- Enuresis alarms;
- Home coagulation testing equipment;
- Non-Wearable external defibrillators;

- Trusses;
- Ultrasonic nebulizers;
- Devices and computers used to assist in communication and speech, except for speech aid prosthetics and tracheo-esophageal voice prosthetics;
- Oral appliances to treat sleep apnea or snoring; and
- Corrective shoes and orthotic devices for podiatric use and arch supports, except those used for diabetic shoes.

Directed Blood Donations
Directed Blood Donations are not covered by this Plan.

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

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

This exclusion does not apply to a prescribed drug if:
- The drug has been approved by the FDA as an "investigational new drug for treatment use"; or
- If it is a drug classified by the *National Cancer Institute* as a Group C cancer drug when used for treatment of a "life-threatening disease" as that term is defined by the FDA.

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

Foot Care
Health care services excluded by the Plan are:
- Routine foot care, such as cutting or removal of corns and calluses, nail trimming, cutting, or debriding, except when performed specifically for the purpose of treating pain related to functional limitations
- Hygienic and preventive maintenance foot care. Examples include:
  - Cleaning and soaking the feet
  - Applying skin creams to maintain skin tone
- Shoes (except for diabetic shoes)
- Treatment of flat feet

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

Genetic Testing
Most Genetic Testing is not covered. Genetic testing is only covered by the Plan if it is Medically Necessary to identify a genetic disease that may be inherited. Please refer to Section 6, Genetic Testing, and Preventive and Wellness Services, to read about Genetic Testing that is covered by the Plan.

Infertility/Reproduction
The following Infertility and Reproductive services are not covered by the Plan:
- Services to reverse voluntary, surgically induced infertility;
- Donor semen, donor eggs and services related to their procurement and storage;
- GIFT procedures;
- Foams and condoms;
- Services and supplies related to conception by artificial means. This means prescription drugs related to such services, such as but not limited to in vitro fertilization, embryo or ovum transplants, gamete intra fallopian transfers and zygote intra fallopian transfers. These exclusions apply to fertile as well as infertile individuals or couples.

- Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
- Surrogate parenting, donor eggs, donor sperm, and host uterus, except when the surrogate is insured under this plan;
- Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue, and ovarian tissue;
- Fetal reduction surgery; and
- Genetic testing of embryos pre or post implantation.

Medical Supplies and Equipment
Health care supplies and equipment not covered by the Plan include medical supplies and disposable supplies, unless provided through Diabetes Services, Home Health Care or covered as Ostomy Supplies. Examples of supplies are:
- Elastic stockings;
- Ace bandages;
- Antiseptics;
- Gauze and dressings;
- Tubing and masks;
- Deodorants (except for ostomy);
- Filters;
- Lubricants;
- Tape;
- Appliance cleaners;
- Adhesive; and
- Adhesive remover.

Mental Health or Substance Abuse Services
This plan excludes the following services related to Mental Health or Substance Abuse 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 course, 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.

Neurobiological Disorders
Health care services excluded under this provision include:
- Mental retardation as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Tuition or services that is school-based for children and adolescents under the Individuals with Disabilities Education Act.
- Learning, motor skills, and primary communication disorders as defined in the current edition of Diagnostic and Statistical Manual of the American Psychiatric Association and which are not part of Autism Spectrum Disorder.

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

Nutrition
Health care services not covered by the Plan are:
- Infant formula and donor breast milk 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 are supplements, electrolytes, and foods of any kind.
- Individual and group nutritional counseling. Services are covered when medical nutritional education services

are provided by an appropriately licensed or registered health care professional; and when nutritional education is required for a disease in which patient self-management is an important component of treatment; and there is a knowledge deficit regarding the disease which requires the intervention of a trained health professional. Please refer to the Nutritional Evaluation, Counseling, and Self-Management Training in Section 6 - Benefits/Coverage (What is Covered).

Other Services
Other health care services not covered by the Plan are:
- Health services for treatment of military service-related disabilities when You are legally entitled to other coverage and facilities are reasonably available to You;
- Health services while on active military duty; and
- Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements.

Pediatric Dental Care – Limitations
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 to two every 12 months
- D1204 Topical application of fluoride (excluding prophylaxis) – Age 15 to 22 - two every 12 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 – Under age 15 - Limited to one per tooth in 60 months
- D2931 Prefabricated stainless steel crown - permanent tooth - Under age 15 - 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 for members up to age six and for primary molars and cuspids up to age 11 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 for members up to age six and for primary molars and cuspids up to age 11 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 36 months
- 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 lifetime

The annual Benefit maximum for non-orthodontic services is $1,200.

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
- D8220 Fixed appliance therapy
- 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 - one in 12 months for patients 13 and older

The lifetime Benefit maximum for orthodontic services is $1,500.

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 gingival 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 24 months of treatment if the service is provided by the same Provider/Provider office.
- Replacement restorations within 24 months are included in the fee for the original restoration.
- Protective restorations (sedative fillings) are allowed when definitive treatment is not performed on the same date of service. The fee for protective restorations is included in the fee for any definitive treatment performed on the same date.
- Therapeutic pulpotomy is limited to baby (deciduous) teeth only; an allowance for an Emergency palliative treatment is made when performed on permanent teeth.
- 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 planing performed within 36-months by the same dentist/dental office.
- Periodontal services, including graft procedures are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
- Bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
- 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:

- D0320 TMJ arthrogram
- D0321 Other TMJ films
- 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
- D7880 TMJ Appliance
- D7899 TMJ Therapy
- 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;
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction;
- Services or treatment provided as a result of intentionally self-inflicted injury or illness;
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;

- Charges for copies of Your records, charts or x-rays, or any costs associated with forwarding/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 police or 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 aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Orthodontic care for dependent children age 19 and over;
- Orthodontic care for members and spouses;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliance;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
- Fabrication of athletic mouth guard;
- Internal bleaching;
- Nitrous oxide;
- Oral sedation;
- Topical medicament center
- Bone grafts when done in connection with extractions, apicoectomies or non-covered/non- eligible implants;
- When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by Us.
- When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by Us.
- All out of network services are subject to the usual and customary maximum allowable fee charges as defined by Us. The member is responsible for all remaining charges that exceed the allowable maximum.
- Services that are not Essential Health Benefits;
- Treatment of injuries or illness covered by workers' compensation or employers' liability laws;

- Services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law;
- Maxillofacial prosthetics.
- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.
- Charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
- Treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- Services covered under the Pediatric Dental Plan but that exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- The fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- Dental case management motivational interviewing and patient education to improve oral health literacy.

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

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

  - Fat injections or fat grafting.
  - Hair removal or replacement by any means.
- Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.
- Treatment of benign gynecomastia (abnormal breast enlargement in males).
- Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery that is required to treat a physiologic functional impairment or which is required by the *Women's Health and Cancer Right's Act of 1998* and described under the *Benefits/Coverages (What is Covered) section of this Policy*.
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
- Wigs, toupees, hair prosthesis, 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 other medical professional to assist a member in ending his or her life are not covered by this plan.

Prescription Drugs Exclusions
The following Prescription drugs and services are excluded under the Plan:
- Allergy serum.
- 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.
- 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 Day's Supply Limit, Quantity or Supply Limits, except under certain circumstances during a state of emergency or disaster.
- General vitamins except as described under the Preventive and Wellness Services of the Benefits/Coverage (What is Covered) section of this Policy.
- Human Growth Hormone prescribed to adults for any reason.
- Immunizations - benefits are not available for immunizations including, but not limited to, autogenous vaccines and immunizations related to foreign travel.
- Marijuana for any reason, including medical marijuana.
- Medication prescribed for the treatment of hair loss.
- Medications available as bulk powders only.
- Medications for conditions that are excluded from coverage.
- Medications that are not approved by the FDA.
- 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 as not proven safe and effective.
- Medications prescribed solely for cosmetic purposes.
- Medications used for prevention of diseases not endemic to United States.
- Medications new to market until reviewed by the Pharmacy and Therapeutics Committee.
- Non-Prescription Medications (medications that do not require a prescription), unless specifically covered

elsewhere in this document, or as mandated by Law.
- Off-label use of medications unless required by Law, then allowed in accordance with Law.
- Oxygen, Medical Devices or Equipment, unless specifically listed as covered.
- 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 Medical Condition treatment.
- Prescription Drug Products for any condition, Injury, Sickness, or Mental Illness arising out of, or in the course of employment for which Benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such Benefits is made or payment of Benefits are received.
- Prescription Drug Products furnished by local, state, or federal governments. Any Prescription Drug Product, to the extent payment or Benefits, is provided or available from the local, state, or federal government (for example, Medicare) whether or not payment or Benefits are received, except as otherwise provided by law.
- Prescription Drug Products 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 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.
- 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 prescriber requests a brand medication when there is a generic equivalent, the brand medication will be covered up to the charge that would apply to the generic medication, minus any required copayment. You will be responsible for Your tier 4 copay 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.

Procedures and Treatments
The following Procedures and Treatments are excluded:
- Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.
- Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
- Psychosurgery.
- Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- Speech therapy that is:
  - Used to improve speech skills that have not fully developed;
  - Considered custodial or educational;
  - Intended to maintain speech communication; or
  - Is not restorative in nature.
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or Medically Necessary treatment of Temporomandibular Joint Disorder, dislocation, tumors, orthognathic surgery, jaw alignment, or cancer.

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

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

This exclusion does not apply to mammography services. Services must be received by a Network Provider.

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

Exceptions to this exclusion are:
Services for Emergency Medical Conditions;
You are treated by a Non-Network Provider while You are receiving care at a Network facility; or
We authorize Medically Necessary care to a Non-Network Provider because the care is not available from a Network Provider.

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

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

Travel
Travel services not covered by the Plan are:
- Non-Network health care services provided in a foreign country, except as required in the case of an Emergency Medical Condition.
- Travel expenses, even though prescribed by a Physician, except as described in the *Travel* provision of the *Benefits/Coverage (What is Covered) section of this Policy*.

Types of Care
Health care services excluded under this provision include:
- Multi-disciplinary pain management programs provided on an inpatient basis;
- Respite care, except as covered under the *Hospice Care* provision of the *Benefits/Coverage (What is Covered) section of this Policy;*
- Rest cures;

- Services of personal care attendants; and
- Work hardening or individualized treatment programs designed to return a person to work or to prepare a person for specific work.

Vision Services
Vision services not covered by the Plan are:
- The purchase cost and fitting charge for eyeglasses; frames; or contact lenses; except as covered for children under age 19.
- Adult eye exams except when Medically Necessary and performed by an Ophthalmologist for medical conditions of the eye, not including keratoconus;
- Implantable devices used to correct a refractive error, such as Intacs corneal implants.
- Eye exercise therapy.
- Surgery to help You see better without glasses or other vision correction, such as radial keratotomy, laser, and other refractive eye surgery.

All Other Exclusions
Items excluded under this provision include the following:
- Administrative services
- Aids or devices that assist with non-verbal communications.
- Ambulance services that are not Medically Necessary.
- Autopsy, except as may be reasonably required by Us at Our own expense.
- Charges for services provided by a stand-by Physician.
- Charges unsupported by medical records.
- Claims received by Us after 12 months from the date service was rendered, except in the event of legal incapacity or as required by law.
- Continuous glucose monitoring for patients who are not Type I diabetics
- Court-ordered testing, except for mental health or substance abuse testing or treatment as required by state law.
- Gym fees or memberships.
- Health services and supplies that do not meet the definition of a *Covered Health Service* - see the *Definitions* section.
- Health services received during service in the armed forces of any country.
- Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
- Inpatient stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- Long-term (more than 30 days) storage of products such as cryopreservation of tissue, blood, and blood products, unless used for a previously scheduled procedure.
- Charges for the collection or obtainment of blood or blood products from a blood donor, including You, in the case of autologous blood donation.
- Medical services and procedures that are not legal.
- Missed and canceled appointments.
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under this Policy when:
  - Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage, or adoption.
  - Conducted for purposes of medical research.
  - Required to obtain or maintain a license of any type.
- Preventive Care services rendered by an out of network provider or at an out of network facility.
- Services performed as a result of complications related to or attributable to services that are specifically excluded from coverage under this *Policy*.
- Services received because of participation in an insurrection, rebellion or riot.
- Services received as a result of a commission of, or an attempt to commit a felony (whether or not charged) or as a result of being engaged in an illegal act or occupation.
- Virtual colonoscopy including CT colonography and capsule endoscopy and colonography.

- Virtual coronary angiography and coronary calcium scans.
- Voluntary, elective abortions and any related services, drugs or supplies are excluded. Exceptions are made when the abortion is deemed Medically Necessary, including to preserve the life or health of the mother if the pregnancy continues to term; or when the pregnancy is the result of an act of rape or incest; or when a likely fatal or long-term morbidity is identified in the fetus during testing; or treatment of complications following a Medically Necessary abortion.

Section 8 - Member Payment Responsibility

YOUR RESPONSIBILITIES

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

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

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

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

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

OUR RESPONSIBILITIES

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

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

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

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

ASSIGNMENT OF BENEFITS

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

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

REQUIRED CLAIM INFORMATION

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

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

NOTICE OF CLAIM OR PROOF OF LOSS FOR REIMBURSEMENT

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

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

CLAIM FORMS

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

You may find the required claim forms on Our Member Hub or by calling Customer Service at the number listed on Your ID card.

PAYMENT OF CLAIMS UPON DEATH

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

TIME FOR PAYMENT OF CLAIMS

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

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

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

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

If a claim for which the claimant is a Provider or Facility has not been paid or denied within 60 days after receipt of the initial claim, We shall send a claim status report to You. Provided, however, that the claims status report is not required during the time We are awaiting information requested. The report shall indicate that the claim is under review and that We are communicating with the Provider or Facility to resolve the matter. While a claim remains unresolved, We shall send a claim status report to the insured with a copy to the Provider 30 days after the previous report was sent

RECOVERY OF OVERPAYMENTS

We may recover overpayments made to a Provider or Facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of North Carolina law. Not less than 30 calendar days before We seeks overpayment recovery or offsets future payments, We shall give written notice to the Provider or Facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery

of overpayments or offsetting of future payments shall be made within the two years after the date of the original claim payment unless the insurer has reasonable belief of fraud or other intentional misconduct by the Provider or Facility, or its agents, or the claim involves a Provider or Facility receiving payment for the same service from a government payor. The Provider or Facility may recover underpayments or non-payments by the insurer by making demands for refunds. Any such recoveries by the Provider or Facility of underpayments or non-payment by the insurer may include applicable interest. The recovery of underpayments or non-payments shall be made within the two years after the date of the original claim adjudication, unless the claim involves a Provider or Facility receiving payment for the same service from a government payor.

TIMELY FILING

Claims for Covered Health Services from a Non-Network or Non-Participating Provider must be submitted to Us within one year (365 days) from the date of service. If Your Provider does not file a claim for You, You are responsible for filing the claim within the one-year deadline. Except in the absence of legal capacity, claims submitted after the deadline are not eligible for benefit payment or reimbursement. If a claim is returned to You because We need additional information, You must resubmit it with the information requested within 90 days of receipt of the request. Claims can be submitted to Us at:

Claim Submissions and Correspondence Address:

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

Section 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, and Annual Deductible charges
- You are responsible for paying, directly to Your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating You is right for You. This includes Network Providers You choose and providers to whom You have been referred.
- You must decide with Your provider what care You should receive.
- Your provider is solely responsible for the quality of the services provided to You.

INCENTIVES TO PROVIDERS

We pay Network Providers through contractual arrangements, some of which may include financial incentives to promote the delivery of quality health care in a cost efficient and effective manner. These financial incentives are not intended to affect Your access to health care.

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

INCENTIVES TO YOU

We may offer You incentives to encourage You to participate in various activities, wellness programs or certain disease management programs. Such activities may include:

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

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

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

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

REBATES AND OTHER PAYMENTS

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

INTERPRETATION OF BENEFITS

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

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

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

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

EVALUATION OF NEW TECHNOLOGY

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

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

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

ADMINISTRATIVE SERVICES

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

INFORMATION AND RECORDS

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

We may use Your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that You may find valuable, and as otherwise permitted or required by law. We may request additional information from You to decide Your claim for Benefits. We will keep this information confidential. We may also use Your de-identified data for commercial purposes, including research, as permitted

by law. More detail about how We may use or disclose Your information is found in Our *Notice of Privacy Practices*. You can obtain Our Notice of Privacy Practices in the Member Hub, on Our website at www.brighthealthcare.com, in Your welcome kit that included Your Identification Card, or by contacting Customer Service at the telephone number listed in *Section 2* of this Policy and on Your ID card.

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

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

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

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

EXTENSION OF BENEFITS

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

EXAMINATION AND AUTOPSY

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

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

MEDICAID REIMBURSEMENT

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

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

- A member is eligible for coverage under his or her state's Medicaid program; and
- We receive proper proof of loss and notice that payment has been made for covered service expenses under that program.

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

WORKERS' COMPENSATION

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

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

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

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

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

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

- If You qualify under North Carolina law to reject workers' compensation coverage as an owner and officer of Your business. We reserve the right to request documentation to substantiate Your lawful rejection of coverage.

LIMITATION OF ACTION

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

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

CHANGE OF BENEFICIARY

Unless the insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

CONFORMITY WITH STATE STATUTES

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

FRAUDULENT INSURANCE ACTS NOTICE

It is against the law to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties for fraud may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the North Carolina Department of Insurance.

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

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

If fraud is suspected, contact Us at the *Customer Service* number listed in Section 2 of this Policy and on Your ID card.

We reserve the right to recoup any benefit payments paid on Your behalf. If We determine that an act of fraud was perpetrated, We may rescind the coverage under this Policy retroactively to the date in which the fraudulent act was committed. We may rescind coverage if You have committed fraud or an intentional misrepresentation of material fact in applying for coverage in or receiving or filing for Benefits. We will provide You with a thirty (30) day advanced written notice prior to rescinding Your coverage.

TIME LIMIT ON CERTAIN DEFENSES

After the Policy has been in effect for two years, in the absence of fraud, no misstatements made by the Subscriber in the enrollment application may be used by Us to cancel this Policy or to deny a claim for Benefits for Covered Health Services.

NOTICES

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

PRE-EXISTING CONDITIONS

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

OTHER INFORMATION YOU SHOULD HAVE

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

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

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

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 thirty (30) day advanced written notice prior to terminating Your coverage.

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

- Loss of eligibility due to the Subscriber no longer living or working in the Service Area served by Bright HealthCare;
- You are actively enrolled under more than one of Our individual or child-only plans. Coverage under the first plan will end as of the effective date of any subsequent Bright HealthCare non-group plan.
- You have ceased enrollment in a bona-fide association under which this Policy is issued, but only if coverage is terminated without regard to any health status related factor.
- We decide not to renew all of Our individual or child-only plans in the State of North Carolina. In this case, We will provide notice of the decision not to renew the plans to all affected individuals and to the State Insurance Commissioner. We will provide notice at least 180 days before Our non-renewal of the plans.
- We decide to discontinue a particular Plan. In this case We will provide ninety (90) days advance written notice to the Subscriber prior to termination of coverage.
- When the State Insurance Commissioner finds that the continuation of Your plan would not be in Your best interest or Your plan is obsolete or Your plan would impair Our ability to meet Our contractual obligations. In this case, We will provide notice of discontinuance at least 90 days prior to the date of discontinuance. We will provide You with the opportunity to purchase any other non-group plan offered by Us.
- We stop operations. We must pay for services for the rest of the time that premiums have already been paid.
- When enrollment was erroneous or inappropriate. If enrollment occurred in error or inappropriately, We reserve the right to rescind the policy.
- We receive a written notice from You instructing Us to cancel Your or Your Dependent's coverage. If any premium has been paid for the time period following the requested date of termination and no claims have been submitted to Us for dates of service after the requested date of termination, We will refund or credit that premium within 30 days of the request for termination. In the case of retroactive terminations, We will not refund or credit any premium when claims have been submitted to Us for dates of service after the requested date of termination.
- For Individual Policies (not Child-Only): An Enrolled Dependent Child reaches age 26. If the Dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon the policyholder for support, the Dependent can remain as a Dependent Child under the Policy. Proof of such dependency may be required within 31 days of the child's attainment of the limiting age, but not more frequently than annually.
- The Spousal relationship, as referred to in Our definition of Spouse, is legally dissolved. Coverage for the Dependent Spouse will end on the last day of the month in which the Spousal relationship is legally dissolved. Once We receive notice of the dissolution, We will adjust Your coverage and premium.
- For Individual Child-Only Policies: A Covered Person reaches age 21. Coverage for the Covered Person reaching age 21 will end on the last day of the month in which the Covered Person turns 21.
- The Subscriber's death. Upon the death of the Subscriber, Dependent coverage may be continued under a new policy with a new ID number. Please contact *Customer Service* at the number included on Your ID card for additional information.
- Coverage will end if premiums are not paid when they are due.
- Fraud, including improper use of Your ID card or intentional misrepresentation of material fact. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact may result in termination or rescission of this Policy. This Policy may also be terminated if You participate in or permit fraud or deception by any Provider, vendor, or any other person associated with this Policy. Termination of Coverage will be effective on the date We mail the written notice of termination to You. Rescissions will be as the coverage

effective date, and it will be as if You were never covered under this Policy. We will provide You with thirty (30) days written notice prior to rescinding coverage.

GRACE PERIOD

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

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

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

PREMIUM PAYMENTS

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

PREMIUM PAYMENTS FROM THIRD-PARTY PAYORS

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

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

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

REINSTATEMENT OF COVERAGE

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

Policy. Any premiums accepted in connection with a reinstatement will be applied to a period for which You have not previously paid premium, but not to exceed sixty days prior to the date of reinstatement.

CERTIFICATE OF CREDITABLE COVERAGE

We will supply a Certificate of Creditable Coverage when Your or Your dependent's coverage under this policy ends or You exhaust continuation of coverage. Keep the Certificate of Creditable Coverage in a safe place. You may request a Certificate of Creditable Coverage while You are still covered under this Policy and up to 24 months following Your termination. You may call the Customer Service to request the Certificate of Creditable Coverage.

Section 12 - Appeals and Grievances

APPEALS AND GRIEVANCES

You may have a concern with Your policy or be dissatisfied with quality of care, a service issue, or the denial of a claim or request for service that You had. Dissatisfaction with quality of care or service may be filed as a Grievance. Dissatisfaction with the denial of a claim or request for service may be filed as an appeal. The Appeals and/or Grievance processes are voluntary, and may be requested by You or Your authorized representative. Below is a brief description of each of these processes.

WHAT TO DO IF YOU HAVE A QUESTION

Contact *Customer Service* at (855) 827-4448. *Customer Service* representatives are available to take Your call and resolve Your inquiry.

WHAT TO DO IF YOU HAVE A GRIEVANCE

Contact *Customer Service* at (855) 827-4448. *Customer Service* representatives are available to take Your call.

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

Bright HealthCare
P.O. Box 16275
Reading, PA 19612

Or, by faxing the request to: 1-888-965-1815

If the *Customer Service* representative cannot resolve the issue to Your satisfaction over the phone, he/she can help You prepare and submit a written Grievance.

ADVERSE DETERMINATION

We consider the following situations to be an Adverse Determination:

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

If We issue a Denial or a Non-Certification, We will send written notification of the Adverse Determination to You and to the Participating Provider that submitted the claim if the health care provider would otherwise be eligible for payment. If the services being denied were received from a Non-Network Provider, We will send You written notification of the denied claim.

INTERNAL REVIEW PROCESS

To begin the internal review process, You must send a written request to Us at the address listed below:

Bright HealthCare
P.O. Box 16275
Reading, PA 19612

Or, by faxing the request to: 1-888-965-1815

Your request for an appeal must include:

- A description of the Adverse Determination;
- The reason You disagree with the Adverse Determination; and
- Any documentation (including medical records) or other written information to support Your position.
- If the Adverse Determination is based on a contractual exclusion, You must submit evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply.

- If Your appeal is related to a claim, the request for the appeal must include the following information:
  - The patient's name and the identification number from the ID card;
  - The date(s) of the medical service(s); and
  - The provider's name.

First-Level Grievance Review
Your Grievance request must be submitted to Us within 180 calendar days after You receive notice of the Adverse Determination You are appealing.

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

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

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

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

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

When a decision is not in Your favor, We will provide a written decision that contains:
- The professional qualifications and licensure of the person or persons reviewing the Grievance.
- A statement of the reviewer's understanding of the Grievance.
- The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the Our position.
- A reference to the evidence or documentation used as the basis for the decision.
- Notice of the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.
- A statement, "You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available in Your state is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency."

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

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

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

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

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

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

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

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

EXPEDITED APPEALS

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

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

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

An expedited appeal request does not need to be submitted in writing. An expedited review may be requested by calling Us directly at 1-855-827-4448.

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

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

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

INDEPENDENT EXTERNAL REVIEW PROCESS

North Carolina law provides for review of Non-Certification decisions by an external, Independent Review Organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to You, arranging for an IRO to review Your case once the NCDOI establishes that Your request is complete and

eligible for review. You or someone You have authorized to represent You may request an external review. We will notify You in writing of Your right to request an external review each time You:

- Receive a Non-Certification decision, or
- Receive an appeal decision upholding a Non-Certification decision; or
- Receive a second-level Grievance review decision upholding the original Non-Certification.

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

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

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

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

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

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

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

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

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

If You choose to provide any additional information to the IRO, You must also provide that same information to Us at the same time using the same means of communication (e.g., You must fax the information to Us if You faxed it to the IRO). When faxing information to Us send it to 1-888-965-1815. If You choose to mail Your information, send it to:

Bright HealthCare
P.O. Box 16275
Reading, PA 19612

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

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

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

- Receive a Non-Certification decision from Us and file a request with Us for an expedited appeal, or
- Receive an appeal decision upholding a Non-Certification decision.

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

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

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

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

For further information about External Review or to request an external review, contact the NCDOI

by mail at:

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

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

Visit https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied/request-external-review for External Review information and Request Form.

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

Section 13 - Information on Policy and Rate Changes

CHANGES TO THIS POLICY

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

CHANGES IN COVERED PERSONS

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

CHANGES TO PREMIUM CHARGE

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

MISSTATEMENT OF AGE

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

ADDRESS CHANGES

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

GUARANTEED RENEWABLE

Guaranteed renewable means that this policy will renew each year on the anniversary date unless terminated earlier in accordance with policy terms listed in *Section 11 – Termination/Nonrenewal/Continuation*.

RENEWAL OF POLICY

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

Section 14 - Definitions

Adverse Determination or **Denial** – Means:

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

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

For Covered Health Services received from a Network Provider, the Allowable 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 Allowable Amount will be in accordance with Our reimbursement policies.

Alternate Facility – A health care facility that provides outpatient health care services.

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

Ancillary Provider – A provider whose services support the work of the primary physician that is treating You.

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

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

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

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

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

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

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

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

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

Child – Means a person who is under the age of 26 and is the Subscriber or Dependent's:
- Natural child;
- Stepchild;
- Legally adopted child;
- Foster child;
- Child placed for adoption;
- Child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order; or
- Child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's Spouse.

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

Child Health Supervision Services – Those preventive services and immunizations required to be provided to an Enrolled Dependent Child up to age 13 as follows:
- 0-12 months: One newborn home visit during the first Week of life if the newborn is released from the Hospital less than 48 hours following delivery; six (6) Well-child visits; one (1) PKU.
- 13-35 months: Three (3) Well-child visits
- 3-6 years: Four (4) Well-child visits
- 7-12 years: Four (4) Well-child visits
- 0-12 years: Immunizations

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

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

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

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

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

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

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

Congenital Anomaly – Something that is unusual or different at the time of a person's birth.

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

Cosmetic Procedures – Procedures or services that change or improve appearance and do not improve physiological function.

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

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

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

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

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

Custodial Care – 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.

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

Days' Supply Limit – This is the number of days of therapy You can receive for each prescription filled and re-filled under this benefit. Days' Supply Limits will be determined by the prescribing Physician and may be reduced by Your prescriber, pharmacist, or state laws impacting Your prescription medication.

Denial or **Adverse Determination** – Means:

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

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

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

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

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

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

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

Durable Medical Equipment – Medical equipment that is all of the following:
- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury, or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury, or their symptoms.
- Is not implantable within the body.

Eligible Individual – A person who meets the Plan's guidelines and is eligible to enroll in a Policy offered by Us**.**

Emergency Ambulance Services – Services provided by an ambulance service following the onset of a medical condition that manifests itself by symptoms of pain, illness or injury that the absence of accessing an ambulance or emergency response by 911 or a designated telephone number to reach a public safety answering point and receiving time sensitive medical attention could reasonably be expected to result in any of the following:
- Placing the health of the individual or, with respect to a pregnant woman, the health of her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:
- Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

Emergency Services or Emergency Care – Health care items and services furnished or required to screen for or treat an Emergency Medical Condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

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

Exchange, also known as the Marketplace, or Healthcare.gov – Is a transparent and competitive online insurance marketplace where people can buy qualified health benefit plans. The Exchange offers a choice of health plans that meet certain benefits and cost standards.

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

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

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

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

Family Annual Deductible – This is the most that a Family of two (2) or more enrollees would pay per calendar year towards their Deductible, before We begin paying for benefits. No individual pays more than the individual Deductible amount.

Formulary/Formulary Drugs – A list of medications covered by Us. Products that are on the Formulary generally cost less than products that are not on the Formulary. 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 that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

Grievance - A written complaint submitted by You about any of the following:

- Our decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a You about a decision rendered solely on the basis that this Policy contains a benefits exclusion for the health care service in question is not a Grievance if the exclusion of the specific service requested is clearly stated in this Policy.

- Claims payment or handling; or reimbursement for services.
- The contractual relationship between You and Us.
- The outcome of an appeal of an Adverse Determination.

Habilitative Services – Health care services that help You keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Hearing aid – A wearable instrument or device designed to aid or compensate for impaired human hearing. "Hearing aid" shall include any parts or ear molds.

Hearing Screening – An exam or test that determines the need for hearing correction.

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

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

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

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

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

Inpatient Rehabilitation Facility – A facility that provides rehabilitative health services on an inpatient basis, as authorized by law.

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

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

Intermittent Care – Skilled nursing care that is provided or needed either:
- Fewer than seven days each Week; or
- Fewer than eight hours each day for periods of 21 days or less.

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

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

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

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

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

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

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

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

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

Mental 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 Health 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.

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

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

Network Pharmacy – A pharmacy that has:

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

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

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

Network Provider or Participating Provider or Network Health Care Professional – Means a provider that has an effective contract to provide services under their specific discipline (either directly or indirectly) with Us. Providers who agree to discount their fees for Our Subscribers without signing a participation agreement are NOT Network/Participating Providers.

Non-Certification - a determination by Us or a utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of emergency services in G.S. 58-3-190, and the requested service is therefore denied, reduced, or terminated. A Non-Certification" is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question if the exclusion of the specific service requested is clearly stated in this Policy. A Non-Certification includes any situation in which We make a decision about a Your condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under this Policy is affected by that decision.

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

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

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

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

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

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

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

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

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

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

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

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

Policy – The agreement issued to the Subscriber that includes all of the following:

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

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.

Positional Plagiocephaly – The asymmetrical shape of an infant’s head due to uneven external pressures on the skull in either the prenatal or postnatal environment. This does not include asymmetry of an infant’s head due to premature closure of the sutures of the skull.

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

Pregnancy – Includes all of the following:

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

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

Prescription Drug Product – Drugs and medications that require a prescription, by law.

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

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

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

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

Primary Care Physician – A physician who directly provides or coordinates a range of health care services for a patient.

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

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

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

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

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

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

Retail Clinic – A walk-in medical clinic located in a retail store or pharmacy that provides treatment for uncomplicated minor illnesses and preventative health care services.

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

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

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

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

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

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

Sickness – A particular type of illness or disease.

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

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

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

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

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

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

Subscriber – An Eligible Person who is properly enrolled under this Policy. The Subscriber is the person (who is not a Dependent) on whose behalf this Policy is issued.

Substance Abuse Services – Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Telemedicine –The delivery of medical services and diagnosis, consultation, or treatment using interactive audio, interactive video, or interactive data communication. Telemedicine visits are considered office visits and the applicable office visit copayment, coinsurance and/or deductible applies.

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

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

Urgent Care Center – A walk-in care facility that treats injuries or illnesses that require care right away, but that are not serious enough to require an emergency room visit.

Usual, Customary, and Reasonable Charge – Is the reasonable median rate paid for similar health care services within the surrounding geographic region 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.

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