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 Insurance Company “Bright Health.” It explains the Benefits for health care services. Benefits are for Covered Persons and are subject to plan terms, conditions, exclusions, and limitations. This Policy is issued when We receive the application and in consideration of any and all required payment(s).

ENTIRE CONTRACT

This Policy includes Your:

- Schedule of Benefits
- Enrollment Application
- Any Attachments or Riders

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

As of the effective date of the Contract, this Policy supersedes all other agreements between the Subscriber and Bright Health. Changes to the Policy must be given to You in writing. Changes to the Policy must be signed by the executive officer of Bright 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:

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

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.

RIGHT TO CANCEL OR RETURN THIS POLICY

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

RENEWAL OF POLICY

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

Information about Defined Terms

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

When You see the words "We," "Us," and "Our,” We are referring to Bright Health. When You see the words "You" and "Your," We are referring to Covered Persons. If the Covered Person is under age 18, “You” and “Your” refer 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:	On Our Website at:
(844) 926-4524	www.brighthealthcare.com
TTY: 711	

Send Claims or other written correspondence to Us at:

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

Send Appeals and Grievances to US at:

P.O. Box 1519
Portland, ME 04104

NON-DISCRIMINATION 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 Health” means Bright HealthCare plans and their affiliates, which are listed below.

Language assistance and alternate formats:
Assistance is available *at no cost* to help You communicate with Us. 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 at (844) 926-4524 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 Health Civil Rights Coordinator
P.O. Box 853943
Richardson, TX 75085-3943
Phone: (844) 202-2154
Email: OAG@brighthealthcare.com

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

- Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
- Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
- Mail: U.S Dept. of Health and Human Services. 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 Health, 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 מיטגלידער 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 በሚገኝ የአባላት አገልግሎት ቁጥር ላይ ይደውሉ።
Burmese	သင့်သည် အင်္ဂလိပ်စကားမဟုတ်သော အျခားဘာသာစကားတစ်ခုအား ဖျတ်ဆို်သျှဖစ်ပါက ဘာသာစကားအခမဲ့ပံ့ပိုးသည့် ဝန်ဆောင်မှုအား သင့်ရဖို်ငပါသည်။ သင့် ID (သက်သေခံ) ကတ်ျပားပေ်ရှိ အဖ်ြွဝင်မ်ားဝန်ဆောင်မှုဌာနအား ဖုန်းခေ်ဆို်ပါ။
Cherokee	ᎣᏍᏓᎵᏍᏕ: ᎦᎢ ᎾᎾᏂᎵᏍᎩ ᎯᎾᏂᏱ ᏏᏃ ᎩᎮᏏ, ᎾᎾᏂᎯᎵᏍᎩ DPᏍᏚPᏍᎩ ᎢᏗᏓᏁᏗᏗᎢ, Ꮳ ᎪᎢᏍᏗ ᏧEGᏳᏗ ᎯᎩ D4ᏯᎢ, ᏂᎯ RGᎾᏙᎢᏍᏓᏁᏩᎢ. ᎾᏍᏆᏃ ᏥᏙᏅᎾ ᏰP DPᏍᏚPᏍᎩ Ꮧ4ᏍᏗ ᎤᎾᎢ GᏐP ACᏍᏓᏁᏗ ᏆᎾᏂᏍᏗ.
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	တိၢ်ဒိဉ် – နမ့ၢ်ကတိၤကျိာ်လၢတမ့ၢ်အဲကလံးကျိာ်ဘဉ်န္ဉာ်, ကျိာ်တၢ်တိစၢမၤစၢတၢ်မၤစၢတဖဉ်, လၢတလိဉ်ဟ့ဉ်အပူၤတဖဉ်အိဉ်လၢနုဂိၢ်နွဉ်လီၤ. ကိးကရၢဖိတၢ်မၤစၢတဖဉ် (နွနှဉ်ဘနုမ့နမလၤဒချ) အနိဉ်ဂ်ၢ်ဖဲန တၢ်အုဉ်သးနိဉ်ဂ်ၢ်ခးကွအဖိဒိဉ်နွဉ်တက့ၢ်.
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 بەردەستن. یەیوەندی 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 ܐܝܟ ܠܫܢܐ ܐܚܪܢܐ ܣܛܪ ܡܢ ܠܫܢܐ ܐܢܓܠܝܙܝܐ، ܗܘܐ ܡܬܝܗܒܐ ܠܟܘܢ ܚܘܠܡܢܐ ܕܥܘܕܪܢܐ ܕܠܫܢܐ ܕܠܐ ܬܫܠܘܡܬܐ. ܩܪܘ ܠܡܢܝܢܐ ܕܫܘܬܦܘܬܐ ܕܡܫܡܫܢܘܬܐ ܕܠܫܢܐ (Member Services)
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 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. 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 on.
- 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 Your health care professionals as soon as possible about any changes in family size, address, phone number, or status with Your Health Benefit plan.

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Section 4 – Eligibility

We offer two (2) types of Individual policies:

- Individual Policies: these policies include coverage for at least one adult age 18 or older and coverage for eligible Dependents.
- Individual Child-Only Policies: these policies include coverage for Children under age 26, without a parent or legal guardian enrolling in the Plan.

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

WHO IS ELIGIBLE FOR COVERAGE

Eligible Subscribers

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

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

Eligible Dependents

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

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

When a Dependent is enrolled, We refer to that person as an Enrolled Dependent or Enrolled Child, as appropriate. For a complete definition of Dependent, Child(ren), and Enrolled Dependent, see the *Definitions* section of this Policy.

WHEN COVERAGE BEGINS

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

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

If You are a new or renewing enrollee with Bright HealthCare and You had coverage with Us in the past twelve (12) months, Your Premiums from the last twelve (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 twelve (12) months must be current, and the first month's Premium for Your new or renewing Policy must be paid before Your Policy becomes effective.

SPECIAL ENROLLMENT PERIOD

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

ENROLLING ELIGIBLE DEPENDENTS

Dependents who have a Qualifying Life Event as defined by state and federal law may be enrolled during the special enrollment period as described below. The special enrollment period is a period

of time in which enrollment is allowed before or after an individual becomes eligible for coverage due to any of the Qualifying Life Events listed below.

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

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

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

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

A Dependent newborn Child must be enrolled within thirty-one (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 after the initial thirty-one (31) days of coverage.

For newly adopted Children (including Children newly placed for adoption), the effective date of coverage is the date of the adoption or placement for adoption. An eligible adopted Child must be enrolled within sixty (60) days from the date the Child is placed in the Subscriber's 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. The monthly Premium for the newly adopted Child is the entire month's Premium. Adopted Child Premiums are not pro-rated.

For all other Dependents, if enrolled within sixty (60) days of becoming eligible, the effective date of coverage will be the first day of the month following the date We receive the enrollment application, any written documentation that may be required to support the effective date of the

qualifying event, and any required Premium. Proof of the qualifying event (e.g., a copy of the marriage certificate, Qualified Medical Support Order, etc.) must be attached to the completed application.

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

IF YOU ARE HOSPITALIZED WHEN YOUR COVERAGE BEGINS

If You are inpatient in a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility on the day Your coverage begins, You should notify Us of Your Hospitalization within twenty-four (24) hours of the day Your coverage begins, or as soon as it is reasonably possible.

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

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

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 Physicians from Our Provider Network.

Participating Providers are listed on Our website at ***www.brighthealthcare.com*** or You can contact *Customer Service* at the telephone number listed in *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's 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.

You may be entitled to coverage for health care services from the following noncontracted providers if you live or reside within 30 paved road miles of the providers that are listed on our website, or if you live or reside in closer proximity to the listed providers than to your contracted providers.

This list may change periodically, please check on our website or call for verification. Please be advised that if you choose a noncontracted provider you will be responsible for any charges not covered by your health insurance plan.

If you have questions concerning your rights to see a provider you can call Customer Service at the number on your member ID card. If Bright HealthCare does not resolve your problem, you may contact the Office of Consumer Health Assistance in the Insurance Department, toll free.

This plan allows You to:

- Choose from Our Network of Participating Providers and Hospitals for Your health care needs;
- Have direct access to eye care providers, mental health care providers, pediatricians, obstetrical or gynecological health care professionals. You do not need Prior Authorization from the plan or from any other person (including a primary care 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 Prior 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 services for specified medical and behavioral conditions for a defined period of time with doctors, hospitals, and Providers who are Out-of-Network until the safe transfer of care to a Network Provider can be arranged.

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

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

- Bone marrow transplants less than six (6) months post-transplant
- End-stage renal disease and dialysis
- 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 thirty (30) days
- Terminal illness with an anticipated life expectancy of six (6) months or less

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 Section 2 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 thirty (30) days of Your Network Provider leaving Our Network. Requests will be reviewed within ten (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. Copayments, Deductibles, or other cost sharing components will be the same as You would have paid for a Provider currently contracting with Us.

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

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

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

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

For information on how to apply for Continuity of Care, contact Customer Service at the telephone number listed in Section 2 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 maintain a Network Access Plan that describes how We monitor the Network of Providers to ensure that You have access to care. The Network Access Plan is maintained at Our offices. Contact Customer Service at the number listed in Section 2 of this Policy and on Your ID Card for the location of the office nearest You.

DESIGNATED FACILITIES AND OTHER PROVIDERS

If You have a medical condition that We believe needs special services, We may direct You to a Designated Facility or designated Physician chosen by Us. If You require certain complex Covered Health Services for which expertise is limited, We may direct You to a Network facility or provider

that is outside Your Service Area. If You are required to travel to obtain such Covered Health Services from a Designated Facility or designated Physician, We may reimburse certain travel expenses at Our discretion. Please refer to Section 6 – Benefits/Coverage, for more information about eligible Travel Expenses.

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

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

RECEIVING NON-EMERGENT CARE FROM NON-NETWORK PROVIDERS

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 approved by an authorization request for Medically Necessary care to a Non-Network Provider because 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 Health Services and You did not have Prior Authorization Prior Authorization from Us, the services will not be covered. You will be responsible for the entire amount that the Provider bills.

Patients receiving the following nonemergency ancillary services may not be billed beyond their in-network cost-sharing amount:

- emergency medicine,
- anesthesiology,
- pathology,
- radiology, and
- neonatology, as well as diagnostic services (including radiology and laboratory services.

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 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.

We will cover emergency services without imposing Prior Authorization requirements. Whether the Provider is in or out of Our network, services will be covered at the in-network level of benefit. You will be responsible for Your Copayment, Deductible and Coinsurance amounts.

PRIOR AUTHORIZED CARE FROM NON-NETWORK PROVIDERS

In a case where We do not have a Network Provider or Specialist within Our network to provide services for a covered Benefit, We 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.

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

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

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 ninety (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 covered at the same cost-share amount whether received from a Network or Non-Network Provider. You will be responsible for Your Copayment, Deductible and Coinsurance amounts.

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

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

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

See Our Provider Directory on Our website at brighthealthcare.com for a list of Network Providers in the Service Area or 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 define Medically Necessary as health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

We may use the specific information in making decisions about Medical Necessity including but not limited to:

- Scientific Evidence, medical literature, and other evidence-based guidelines
- Professional organization practice guidelines
- Expert Opinion
- Consideration of cost-effectiveness compared to alternative interventions, including no intervention
- 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 an Out-of-Network Provider when services could have been rendered In-Network, You may be required to pay those charges in full. We provide a network of Providers that meets all applicable network adequacy requirements. However, if We determine that a gap exists in Our network, We may approve treatment with an otherwise Non-Network Provider on a case-by-case basis and limited in scope in accordance with Our *Out-of-Network Exceptions* Policy.

PRIOR AUTHORIZATION

Prior Authorization is the process of reviewing a request for health care services prior receiving care. Prior 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 Prior Authorization

Who is responsible for obtaining Prior Authorization?

If You are receiving care from a Network Provider, the Network Provider is responsible for obtaining Prior Authorization before they provide these services to You. If the Provider fails to obtain Prior Authorization and the service is denied, the Provider may not bill You for any balances other than Your Copayment, Deductible or Coinsurance amounts after the Provider receives payment for Us.

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

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

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

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

Standard Prior Authorization

The Prior Authorization review process requires the full cooperation of the requesting Physician in order for Us to evaluate the pertinent information and make a coverage determination. We must make Our decision within fifteen (15) calendar days of receiving the Prior Authorization request and Physician's statement. You can request an expedited exception if You or Your Physician believe that Your health could be seriously harmed by waiting fifteen (15) calendar days for a decision. If Your request to expedite is granted, We must give You a decision within seventy-two (72) hours after We receive the supporting statement from Your Physician. The timeframe for making a coverage determination may be extended if the Prior Authorization request lacks sufficient information or if there is a situation beyond Our control (for example, severe weather or declaration of a state of emergency).

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

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

If You do not obtain the necessary Prior Authorization prior to scheduling services, those services will be denied as not have been Prior Authorized.

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

UTILIZATION MANAGEMENT

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

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

DECIDE WHAT SERVICES YOU SHOULD RECEIVE

Care decisions are between You and Your health care Provider. We do not make decisions about the kind of care You should or should not receive. We make determinations of benefits according to 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 ID Card every time You request health services. If You do not show Your ID Card, the Provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that You may be unable to collect any Benefits owed to You. The billing address used is based on the plan under which Your coverage is issued. Therefore, it is important that You verify that Your Provider has the correct billing information on file for Your plan.

MEMBER COST-SHARING REQUIREMENTS

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

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

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

Out-of-Pocket Maximum is the maximum amount of Deductible, Coinsurance, or Copayments You pay every 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 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 people's combined Out-of-Pocket expenses reach the Family Out-of-Pocket Maximum, Covered Persons under the Family policy will have no further obligation to pay charges for 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 include the Schedule of Benefits and any Amendments
- Make factual determinations related to Benefits

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

When receiving Emergency care from a Non-Network Provider in a Non-Network Facility, payment from the plan will be limited to the Allowable Amount. The Allowed Amount for Emergency Services from an Out-of-Network Provider will be the greatest of the following:

- Amount negotiated with In-Network Providers for the Emergency service.
- Amount for the Emergency service calculated using the same method We generally use to determine payments for Out-of-Network services but substituting the In-Network cost-sharing for the Out-of-Network cost-sharing, or
- Amount that would be paid under Medicare for the Emergency service.

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 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:

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

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

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

Note: In listing services or examples, when We 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 of this Policy.

COVERED HEALTH SERVICES

Refer to Section 5, *How to Access Your Services and Obtain Approval of Benefits*, to determine if the services listed below require Prior Authorization.

Adoption Indemnity Benefit
Bright HealthCare will pay $4,000 payable to You in connection with an adoption of a child, when the adopted child is placed with You within 90 days of the child's birth. And the adoption is finalized within one year of the child's birth. In the event You adopt more than one newborn from a single pregnancy (for example, twins), only a single $4,000 adoption benefit is available.
This Benefit is subject to Coinsurance, Copays, and Deductibles applicable to the maternity Benefit as indicated on Your Summary of Benefits.

Adult Dental
Covered in plans that have an Adult Dental Rider attached.

Allergy Testing and Treatment
Covered Health Services under this section include testing and treatment and allergy shots.

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

- Emergency ground or air ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency health services can be performed.
- Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) between facilities only when the transport is a result of any of the following:
  - Transfer from a Non-Network Hospital/Facility to a Network Hospital/Facility
  - Transfer to a Hospital that provides a higher level of care than was available at the original Hospital/Facility
  - Transfer to a more cost-effective acute care Facility
  - Transfer from an acute Facility to a sub-acute Facility/setting

Non-emergent air transportation requires Prior Authorization.

Autism Spectrum Disorders (ASD)
Covered Health Services under this section include coverage for the assessment, diagnosis, and treatment of Autism Spectrum Disorders. Treatment covered includes:

- Behavior training and management and applied behavior analysis, including but not limited to consultations, direct care, supervision, or treatment, or any combination thereof, provided by autism service Providers
- Evaluation and assessment services
- Habilitative or rehabilitative care, including but not limited to, occupational therapy, physical therapy, speech therapy, or any combination of those therapies
- Pharmacy and medication as covered under the terms of this Policy
- Psychiatric care
- Psychological care, including family counseling
- Therapeutic care, which includes behavioral analysis, Habilitative or Rehabilitative services

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

Chemotherapy Services – Outpatient
Covered Health Services under this section include 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 health care professionals when both of the following are true:

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

Benefits under this section include:

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

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

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

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

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

- The treating Physician, recommends participation in the clinical trial after determining that participation in the clinical trial has the potential to provide a therapeutic health benefit to the Covered Person;
- The 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.

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

- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- items and services customarily provided by the research sponsors free of charge for any enrollee in the trial;
- items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and
- 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.

COVID-19 Testing, Treatment and Vaccinations
Testing, vaccinations, and treatment for services related to COVID-19 are Covered Health Services 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.

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

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

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

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

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

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

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

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

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

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

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 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:

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

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

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

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

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

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

This includes:

- Professional Services include services rendered by the Emergency room Physicians, consulting Physicians, pathologists, radiologists, and anesthesiologists. This includes acute Emergency Care for Life-threatening injury or illness is covered in conjunction with attempted suicide or anorexia/bulimia.
- Placement in an observation bed or a Crisis Stabilization Unit for the purpose of reducing the severity of Your Mental Health and/or Substance Use Disorder symptoms, when Medically Necessary (rather than being admitted to a Hospital for an Inpatient Stay)
- Admission for inpatient hospitalization only during the time that Your condition meets the definition of an Emergency. If You are admitted to a Non-Network facility through the emergency room, You, Your Physician or Hospital must notify Us within 24 hours, or as soon as reasonably possible.

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).

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
- Therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.
- Services are in accordance with the A or B recommendations of the U.S. Preventive Services Task Force (USPSTF).

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

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

Coverage under this section includes charges for:

- The Facility
- Supplies and equipment
- Physician services

Home Health Care
Covered Health Services under this section include services received from a Home Health Agency that is both of the following:

- Ordered by a Physician
- Provided in Your home by a certified Home Health Agency

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

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

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

We will determine if coverage is available by reviewing both the skilled nature of the service, the need for Physician-directed medical management, and if the service was or will be a cost effective alternative to other care settings. 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, inhalation), social work services, medical supplies furnished by the Home Health Agency during visits, nutrition counseling by a nutritionist or dietician, infusions, home health aide services that are supervised by a registered nurse or licensed therapist, and Durable Medical Equipment.

Home Health services are limited to 30 visits per calendar year.

Hospice Care
Covered Health Services under this section include hospice care that is recommended by a

Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill.

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

Hospice care includes:

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

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

Hospice Care services are limited to a 6-month period every three (3) years.

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

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

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

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

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

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

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

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

- Services, supplies, and non-Physician services received during an Inpatient Stay.

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

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

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

Coverage is limited to thirty (30) days per calendar year for Skilled Nursing.

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

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

Lab, X-ray, and diagnostic services for preventive care are described under *Preventive Care Services* section of this Policy.

Medical Foods for Inborn Metabolic Disorders, Including Phenylketonuria (PKU)
Covered Health Services under this section include Medically Necessary Medical Foods for home use for which a participating Physician has issued a written, oral, or electronic prescription. Benefits are described under the "Covered Medications and Products" provision of the *Benefits/Coverages (What is Covered)* section of this Policy.

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

Some covered items may include:
- Ostomy Supplies
    - Pouches, face plates, and belts
    - Irrigation sleeves and bags
    - Skin barriers
- Catheter Supplies
- Tubing and connectors for delivery pumps

- Burn garments
- Supplies related to insulin pumps

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

Mental Health and Substance Abuse Services
Covered Health Services under this section include treatment for Mental Health Disorders and substance use 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.

Eating disorders, such as anorexia and/or bulimia, are payable under medical benefits while life-threatening, as determined by Us. When the condition is no longer life-threatening, benefits are payable under Mental Health and require Prior Authorization.

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

Inpatient Care
Covered Health Services include inpatient hospitalization for Mental Health Disorders and for substance use 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:
- Crisis intervention
- Diagnosis
- Medication management
- Mental health, Substance Use Disorder, and chemical dependency evaluations and assessment
- Referral services
- Short-term individual, family, and group therapeutic services
- Treatment planning

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.

Outpatient Therapies – Rehabilitative and Habilitative Services
Covered Health Services under this section include short-term outpatient Habilitative and Rehabilitative Services, limited to 20 habilitative and 20 rehabilitative visits combined between:
- Physical therapy;
- Occupational therapy; and

- Speech 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.

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 Prior Authorization is obtained. Teeth must be misaligned causing functional problems that compromise oral and/or general health. Benefits for Medically Necessary orthodontics will be provided in periodic payments based on continued enrollment.

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

Prior Authorization

Pediatric Vision Care

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

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

Covered Health Services under this section include routine vision examinations, including refractive examinations to determine the need for vision correction when they are provided by a Network Provider. One (1) vision examination is covered each calendar year.

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

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

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

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

When these services are performed in a Physician's office, Benefits are described in the *Physician's Services for Sickness and Injury* section of this Policy.

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

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

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

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

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

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

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

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

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

- We may transfer You to the nearest appropriate Network or Participating facility for Medical Necessary post-stabilization care.

- If You 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 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 vaginal delivery
- 96 hours for the mother and newborn Child following a cesarean section delivery

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

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

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

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

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

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

If the pharmacy does not have the necessary information from Your ID Card, it will not be able to provide prescriptions according to Your Benefit. If You use a Network Pharmacy but do not use Your ID Card, You may be asked to pay the pharmacy's requested or usual and customary price for the medication. You will need to submit a claim to Us to consider the prescription for reimbursement under Your Benefits. You will always be responsible for any Deductibles, Copayments, Coinsurance, or other limits under this Benefit. Only Pharmacies that participate in Our Pharmacy Network are able to fill Your prescriptions under this Benefit.

Pharmacy Network
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 brighthealthcare.com or call the Customer Service number 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. Call the Customer Service telephone number listed in Section 2 of this Policy and on Your ID Card to find out which Providers are in the Specialty Pharmacy Network program.

Mail Order Medications / Network Benefits
You may get many of Your medications through the mail order pharmacy service or from a Participating retail pharmacy. Form mor information, or to sign up, go to brighthealthcare.com.

Formulary List
Our Pharmacy and Therapeutics committee has created a list of Prescription Drug Products for this Plan, called a Formulary. The Formulary is referenced to determine what You pay at the pharmacy and any additional requirements for covered Prescription Drug Products under the plan.

Products on the Formulary are covered differently than products not listed on the Formulary. Your cost for prescriptions will vary depending on the Formulary status of each specific medication. In general, medications on the Formulary are intended to cost less than medications not on the Formulary. The Formulary contains both Brand-Name and Generic medications.

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

You may view the Formulary at Our website brighthealthcare.com or contact Our Pharmacy Customer Service at the telephone number 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 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 other Quantity or Supply Limits. When a Specialty Prescription Drug Product is packaged or designed in a manner that provides more or less than a consecutive 30-day supply, the Copayment and/or Coinsurance that applies may be adjusted to reflect the number of days dispensed.

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

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

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

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

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

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

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

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

If You have stage four advanced metastatic cancer, You are not required to undergo Step Therapy for a covered medication that has been approved by the U.S. Food and Drug Administration, or other recognized body, for the treatment of stage four advanced metastatic cancer.

Exceptions

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

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

- Ask Your health care Provider if there is another covered medication that will work for You.
- Your health care Provider can ask Us to make an exception to cover a medication or to remove the medication restrictions or limits.

Examples of exceptions:

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

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

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.

Standard and expedited exception requests will be reviewed in accordance with state specific timeframes. Expedited exception requests are appropriate for exigent circumstances, which means the person for whom the request is being made is suffering from a health condition that may seriously jeopardize their life, health, ability to regain maximum function, or the person is undergoing a current course of treatment using a non-formulary drug.

If we grant an approval of an exception request, we will provide coverage until the authorization expires.

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

<u>Off-Label Cancer Medications</u>
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 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 compendia: (1) National Comprehensive Cancer Network (NCCN), (2) American Hospital Formulary Service (AHFS) DrugDex, (3) LexiComp, or (4) Clinical Pharmacology.

A Prescription Drug Product includes a drug approved by the FDA prescribed to treat cancer during

certain clinical trials as described in the Policy.

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

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

Drug Tiers
Coverage will be paid according to the medication classification (e.g. Preventive, Generic, Preferred/Non-Preferred Brand Drugs or Specialty Prescription Drug Products) and subject to the terms of the "Prescription Drug" provision of the *Benefits/Coverages (What is Covered)* section of this Policy and in accordance with state Regulations. Your cost share amounts for each drug tier can be found in Your Schedule of Benefits. You can determine the tier of Your medication on the Plan Formulary.

Your Prescription Drug Benefit includes coverage for the following drug tiers:
Tier 1: Preventive Medications with no member cost share under the Affordable Care Act
Tier 2: Preferred Generic Medications
Tier 3: Non-Preferred Generic Medications; Preferred Brand Medications
Tier 4: Non-Preferred Generic Medications; Non-Preferred Brand Medications
Tier 5: Specialty Medications and Formulary Exceptions
Tier 6: $0 Generic Drugs. This tier is designated for a specific list of generic drugs for some plans.

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

Covered Medications and Products
Covered products are subject to Deductibles, Copayments and/or Coinsurance, Formulary status, Name 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 Utah recognizes such products as requiring a prescription or mandates coverage as such.
- Insulin is covered as a prescription product, along with syringes, and items required for monitoring diabetes treatment and testing strips, ketone urine test strips, lancets and related devices, pen delivery system for insulin administration, insulin syringes, visual aids to support the visually impaired with the proper dosing of insulin (except eyewear), Prescription Medications for treatment of diabetes (oral medications), and glucagon. For most plans, Your cost for a thirty (30) day supply of insulin for each therapy category will not exceed $28 or $94 for ninety (90) day supply. 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 only cover the Formulary prescription ingredient. Any over the counter medications or ingredients included in the compound are not covered.

- Phenylketonuria (PKU) formulas and special food products are covered, and subject to the same Deductibles, Copayments, 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.
- Contraceptive 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 timeframe, there must be an explanation of the Medical Necessity for the quantities. If this information is not provided to Us, there may be a delay in processing the claim or the claim may be denied.

Prescription Eye Drop Refills

Prescription eye drop refills are allowed for a Covered Person if the Refill is requested once 70% of the initial days' supply submitted by the pharmacy has been used. For example, after the first 21 days for a 30-day supply of eye drops, 42 days for a 60-day supply of eye drops, or 63 days for a 90-day supply of eye drops 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 (3) months.

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 Prior Authorization criteria specific to the medications at the time of the synchronization request.
- The medications are of a formulation that can be effectively split over required short-fill periods to achieve synchronization.
- The medications do not have quantity limits or dose optimization criteria or requirements that would be violated in fulfilling synchronization.

Split Fill Program

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

Opioid Dependence

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

What You Must Pay
You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit information table for Generic and Name Brand 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:
- Prior Authorization
- Step therapy protocol
- Our exceptions and appeals process.

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

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

Preventive Medications
Covered Health Services under this section include preventive medications in accordance with the A or B recommendations of the USPSTF:

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

Preventive and Wellness Services
Covered Health Services under this section include A & B Preventive Health Care services recommended by the U.S Preventive Task Force (USPSTF). You can find a list of these services

at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.

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

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

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

- Artificial face, eyes, ears, and noses
- Bionic, myoelectric, microprocessor-controlled, and computerized Prosthetics are covered in accordance with recommended guidelines and criteria
- 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
- Prosthetics will be covered in accordance with recommended guidelines and criteria
- Speech aid prosthetics and tracheo-esophageal voice prosthetics
- 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.

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

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

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

Radiation Services – Outpatient
Covered Health Services under this section include radiation oncology treatment received on an outpatient basis at a Hospital or Alternate Facility. Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

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

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

Reconstructive Procedures
Covered Health Services under this section include reconstructive procedures when the primary

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

Cosmetic Procedures are excluded from coverage. 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

These Benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical Benefits provided under this Plan. See the *Schedule of Benefits (Who Pays What)* section of this Policy 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 ID Card.

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

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

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

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

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

Travel Expenses
Covered Services under this Benefit include reimbursement for travel expenses primarily related to Transplantation Services, including meals and lodging when it is necessary for a Covered Person to receive care from a designated Center of Excellence Facility that is located more than 30 miles from the Covered Person's home.

Travel expenses are reimbursable if We direct You for treatment at a Facility more than 30 miles from Your home because treatment is not available In-Network, within Our Service Area.

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

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

If You need assistance with reimbursement for travel expenses, contact Customer Service at 1-844-926-4524.

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, earache, sore throat, and fever.

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

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

BENEFIT LIMITATIONS

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

BENEFIT EXCLUSIONS

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

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

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.

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."

Alternative Treatments

Health care services excluded under this provision include the following:

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

Bariatric Surgery

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

Chiropractic Care

Chiropractic care and services associated with Chiropractic Care are excluded from coverage under this Plan.

Custodial or Domiciliary Care

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

of a supervising licensed nurse.

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

Dental Care
Dental care, except as defined under Section 6, *Pediatric Dental Care* (which includes dental x-rays, supplies and appliances, and all associated expenses, including hospitalizations and anesthesia) is excluded (except as provided under an Adult Dental Rider). This exclusion does not apply to dental care (oral examination, x-rays, extractions, and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

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

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

Endodontics, periodontal surgery, and restorative treatment are excluded except as defined under Section 6, *Pediatric Dental Care*.

Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums is excluded, except as defined under Section 6, *Pediatric Dental Care*. Examples include:

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

Dental implants, bone grafts, and other implant-related procedures are excluded except when related to accident-related dental services or for services related to the treatment of cleft lip and cleft palate.

Dental braces (orthodontics) are excluded, except as defined under Section 6, *Pediatric Dental Care*, or when Medically Necessary.

Routine dental care for adults is excluded.

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

Dentures, bridges, crowns, and other dental prostheses are excluded. This exclusion does not apply to dental services required for the direct treatment of a medical condition such as treatment for cleft lip or cleft palate for which Benefits are described in Section 6, or for accident-related dental services received within 12 months from the date of the accident or Injury. Dental services received more than 12 months after the accident or Injury are not covered.

Accidental Injury dental services are excluded. This exclusion applies to Outpatient Services, Physician Home Visits and Office Services, Emergency Care, and Urgent Care Services for dental work and oral surgery for the initial repair of an Injury to the jaw, sound natural teeth, mouth, or face as a result of an accident.

Anesthesia for dental services or dental care is excluded from coverage.

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

- Cold packs
- Cold-circulating devices

- Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes
- Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics
- Devices used specifically as safety items or to affect performance in sports-related activities
- Enuresis alarm
- Home coagulation testing equipment
- Non-wearable external defibrillator
- Oral appliances to treat sleep apnea or snoring
- Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics (except for diabetic shoes), cranial banding and some types of braces, including over the counter orthotic braces. This does not apply to equipment for the treatment of positional plagiocephaly.
- TENS units
- Trusses
- Ultrasonic nebulizers

Directed Blood Donations
Directed blood donations are excluded from coverage.

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

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

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

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

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

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

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

Genetic Testing
Genetic testing is excluded unless it is Medically Necessary for the identification of genetically linked inheritable disease. Please refer to Section 6, *Genetic Testing and Preventive and Wellness Services*, for information about Genetic Testing that is covered by the plan.

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

Infertility & Reproductive Services
Health care services excluded are:

- All services and supplies related to conception by artificial means. This means prescription drugs related to such services such as, but not limited to, invitro fertilization, ovum transplants, gamete intra-fallopian transfer, and zygote intra-fallopian transfer are not covered. These exclusions apply to fertile and infertile individuals or couples
- Artificial insemination, donor semen, donor eggs and services related to their procurement and storage
- Fetal reduction surgery
- Genetic testing of embryos pre-or post-implantation. Genetic testing or embryos may be authorized in certain circumstances with preapproval from the Plan.
- 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
- Medications to treat sexual dysfunction
- Services for treatment of involuntary infertility
- Services to reverse voluntary, surgically induced infertility
- Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue, and ovarian tissue
- Surrogate parenting, donor eggs, donor sperm, and host uterus, except when the surrogate is insured under this plan

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

- Ace bandages
- Adhesive
- Adhesive remover
- Antiseptics
- Appliance cleaners
- Deodorants (except for ostomy)
- Elastic stockings
- Filters
- Gauze and dressings
- Lubricants
- Tape
- Tubings and masks
- Urinary catheters

Mental Health or Substance Use Services
This plan excludes the following services related to Mental Health or Substance Use 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 services such as 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; Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by Us.

This exclusion does not apply to treatments related to Habilitative Services.

Nutrition
Health care services excluded under this provision include the following:

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

Other Services
Health care services excluded under this provision include the following:

- Health services for treatment of military service-related disabilities, when You are legally entitled to other coverage and facilities are reasonably available to You
- Health services while on active military duty
- Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements.

Pediatric Dental Care – Limitations
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 voluntary participation in 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 listed 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.
- Services and treatment which are Experimental or Investigational.
- Charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
- Treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- Services covered under the Pediatric Dental Plan but 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, or Convenience
Items excluded under this provision include the following:
- Beauty/barber services
- Guest service
- Television
- Telephone
- Supplies, equipment, and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners, air purifiers and filters, dehumidifiers
  - Batteries and battery chargers
  - Car seats
  - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners
  - Electric scooters
  - Exercise equipment
  - Home modifications such as elevators, handrails, and ramps
  - Hot tubs
  - Humidifiers
  - Jacuzzis/ Whirlpools/ Saunas
  - Mattresses
  - Medical alert systems
  - Motorized beds
  - Music devices
  - Personal computers
  - Pillows
  - Power-operated vehicles
  - Radios
  - Speech generating devices
  - Stair lifts and stair glides
  - Strollers
  - Treadmills
  - Vehicle modifications such as van lifts
  - Video players

Physical Appearance
Health care services excluded under this provision include the following:
- Cosmetic Procedures as defined in the *Definitions* section of this Policy. Examples include:
  - Fat injections or fat grafting.
  - Hair removal or replacement by any means.
  - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.

- 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.
- 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.

- Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.
- Treatment of benign gynecomastia (abnormal breast enlargement in males).
- Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery that is required to treat a physiologic functional impairment or which is required by the Women's Health and Cancer Right's Act of 1998 and described under the *Benefits/Coverages (What is Covered)* section of this Policy.
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
- Wigs, toupees, hair transplants or hair weaving. except as covered under Prosthetic Devices for Covered Persons undergoing treatment for cancer or other conditions treated by chemotherapy or radiation therapy.

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

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

- 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 Days' Supply Limit, Quantity or Supply Limits.
- General vitamins except as described under the "Preventive and Wellness Services" provision of the *Benefits/Coverage (What is Covered)* section of this Policy.
- Human Growth Hormone prescribed to adults for any reason.
- Immunizations - benefits are not available for immunizations including, but not limited to, autogenous vaccines and immunizations related to foreign travel.
- Marijuana, including but not limited to medical marijuana for any reason.
- Medication prescribed for the treatment of hair loss.
- Medications available as bulk powder only.
- Medications for conditions that are excluded from coverage.
- Medications not approved by the FDA.
- 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 used to treat Sexual Dysfunction.
- Medications new to market until reviewed by the Pharmacy and Therapeutics Committee.
- Non-Prescription Medications (medications that do not require a prescription), unless specifically included as covered elsewhere in this document or mandated by law.
- Off-Label Use of medications unless required by law, then allowed in accordance with law.
- 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 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 or Benefits are received.
- Prescription Drug Products furnished by local, state, or federal government. Any Prescription Drug Product to the extent payment or Benefits is provided or available from the local, state, or federal government (e.g., Medicare) whether or not payment or Benefits are received, except as otherwise provided by 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* provision of the *Benefits/Coverage (What is Covered)* section of this Policy.
- Topical medications for the treatment of onychomycosis of the toenails.
- Unit-dose or re-packaged medications, or costs related to re-packaging of available covered medications.

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

- 30-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 prescriber requests a Brand Name medication when there is a Generic equivalent, the Brand Name medication will be covered up to the charge that would apply to the Generic medication, minus any required Copayment.
- 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.

Private Duty Nursing
Services for nursing care that are provided to a patient on a one-to-one basis by licensed nurses are excluded from coverage under this plan except as provided under the Home Health Care or Hospice Care Benefit.

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

- Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures such as abdominoplasty or abdominal panniculectomy, and brachioplasty.
- Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Medical and surgical treatment for snoring, except when provided as a part of treatment

for documented obstructive sleep apnea.
- Psychosurgery.
- Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- Speech therapy except as required for habilitative treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, congenital anomaly, or Autism Spectrum Disorders.
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or Medically Necessary treatment of TMJ, dislocation, tumors, orthognathic surgery, jaw alignment, or cancer.
- Remote surgical neuromonitoring.

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

This exclusion does not apply to mammography.

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

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

Services Rendered by a Non-Network Provider
Generally, services from Non-Network Providers are not covered.

Exceptions to this exclusion may be:
- Emergency Health Services
- You are treated by a Non-Network Provider while receiving care at a Network Facility
- We authorize Medically Necessary care to a Non-Network Provider because the care is not available from a Network Provider

Benefits and services from Non-Network Providers, except in the case of a medical Emergency, or when Pre-Authorized by Us are excluded from coverage.

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

Temporomandibular Joint Disorder (TMJ)
Services for the treatment of TMJ, including diagnostic x-rays, lab testing, physical therapy, and surgery are excluded from coverage under this 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
Health care services excluded under this provision include the following:

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

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

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

Vision Services
Health care services excluded under this provision include the following:

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

All Other Exclusions
Items excluded under this provision include the following:

- Administrative services
- Aids or devices that assist with non-verbal communications.
- Ambulance services that are not Medically Necessary.
- Autopsy, except as may be reasonably required by Us at Our own expense.
- Charges for services provided by a stand-by Physician.
- Charges in excess of the Allowed Amount or in excess of any specified limitation.
- Charges unsupported by medical records.
- Claims received by Us after 12 months from the date service was rendered. Failure to file the notice or proof of loss within the time specified does not invalidate the claim if the insured can show that it was not reasonably possible to file it within the prescribed time limit, 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 received in consequence of being intoxicated or under the influence of any narcotic that is a direct result of an illegal activity, unless administered on the advice of a Physician. Being intoxicated or under the influence is not illegal unless found guilty of participating in illegal activity.
- Health services and supplies that do not meet the definition of a Covered Health Service as noted in the *Definitions* section of this Policy.
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
- Hypoglossal nerve stimulation for sleep studies is not covered.
- Inpatient Stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- Long-term care/nursing home care
- Long-term (more than 30 days) storage of products such as cryopreservation of tissue, blood, and blood products.
- Medical services and procedures that are not legal.
- Missed and canceled appointments.
- Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under this Policy when:
    - Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage, or adoption.
    - Related to judicial or administrative proceedings or orders unless Medically Necessary and for covered services under this Policy.
    - Conducted for purposes of medical research.
    - Required to obtain or maintain a license of any type.
- Preventive Care services rendered by an Out-of-Network Provider or at an Out-of-Network Facility.
- Services performed as a result of complications related to or attributable to services that are specifically excluded from coverage under this Policy.
- Services received because of voluntary participation in an insurrection, rebellion, or riot.
- Services received as a result of a voluntary 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
You must show Your ID card every time You receive health care services. If You do not show Your ID Card, Your Provider may not bill Us for Your services. Any delay may cause You to be unable to collect Benefits owed to You. You must show Your ID Card at the pharmacy when You receive prescription drugs. The information on Your ID Card helps the pharmacy verify that You are covered. It also helps determine the cost of Your medications. If the pharmacy does not have the information from Your ID Card, they will not be able to provide Your medication at Your plan Benefits. If You do not show Your ID Card, You may pay full price for Your medication.

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

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

Pay the Cost of Excluded Services
You must pay for services that are not covered. These are called Excluded Services. Review the *Limitations/Exclusions (What is Not Covered)* section so You know what is not covered.

OUR RESPONSIBILITIES

Pay Our Portion of the Cost of Covered Health Services
We pay for Covered Health Services as shown in the *Schedule of Benefits (Who Pays What)* and *What is Covered* sections of this Policy. 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 of this Policy 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 such as disease management, health education, and patient advocacy. It is Your decision if You want to participate in these programs. We recommend that You discuss them with Your Physician.

Section 9 – Claims Procedure (How to File a Claim)

IF YOU RECEIVE COVERED HEALTH SERVICES FROM A NETWORK PROVIDER

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

ASSIGNMENT OF BENEFITS

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

REQUIRED CLAIM INFORMATION

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

- Subscriber's name and address.
- Patient's name and date of birth.
- ID number stated on Your ID Card.
- Name, address, Tax ID, and NPI number of the Provider of the service(s).
- Date that services were received.
- Name and address of any ordering/referring Physician.
- ICD-10 diagnosis code from the Physician.
- Itemized bill from Your Provider that includes the Current Procedural Terminology (CPT) codes for each charge.
- Date the Injury or Sickness began.
- 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 must be furnished to Us within twenty (20) days after the occurrence of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Electronic submission of the notice of claim is acceptable as submission on paper. Failure to furnish such notice of claim within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time.

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

PROOF OF LOSS

Written proof of loss must be furnished to Us within ninety (90) days after the termination of the period for which We are liable and, in case of claim for any other loss, within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

Failure to give any notice or file any proof of loss required by the policy within the time specified in the policy does not invalidate a claim made by the insured, if the insured shows that it was not reasonably possible to give the notice or file the proof of loss within the prescribed time and that notice was given or proof of loss filed as soon as reasonably possible

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

PAYMENT OF CLAIMS UPON DEATH

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

FINALIZATION OF CLAIMS

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

TIMELY FILING

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

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

Failure to give any notice or file any proof of loss required by the policy within the time specified in the policy does not invalidate a claim made by the insured, if the insured shows that it was not reasonably possible to give the notice or file the proof of loss within the prescribed time and that notice was given or proof of loss filed as soon as reasonably possible

TIME OF PAYMENT OF CLAIMS

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

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

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 the Benefits. Network Providers are independent practitioners who run their own offices and facilities. We are not liable for any act or omission of any Provider.

YOUR RELATIONSHIP WITH PROVIDERS

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

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

INCENTIVES TO PROVIDERS

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

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

INCENTIVES TO YOU

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

REBATES AND OTHER PAYMENTS

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

INSPECTION OF POLICY

If for any reason You are not satisfied with the plan, You may return it to Us with Your ID Card within 10 days following Your effective date. We will refund any fees You have paid and obtain refunds for any Benefits that We have paid to You or Your Provider.

INTERPRETATION OF BENEFITS

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

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

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

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

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

EVALUATION OF NEW TECHNOLOGY

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

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

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

ADMINISTRATIVE SERVICES

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

INFORMATION AND RECORDS

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

signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

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

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

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

CHANGE OF BENEFICIARY

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

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 coverage will not affect the Covered Services covered under this Policy, except as follows:

- If You receive a service that would cover both by Medicare and this Policy, we will allow no more than the amount allowed by Medicare for the same Covered Health Service when calculating Benefits payable under the terms of this Policy. All Benefits payable under this Policy are subject the applicable Deductible, Copayment and/or Coinsurance for the Covered Health Service as outlined in the Schedule of Benefits.
- If You or a Dependent are entitled to Medicare or if a Member of this Policy becomes eligible for Medicare by reason of age, disability, End Stage Renal Disease or any other eligibility category, We will consider what Medicare would pay to the extent permitted by law. This means that We will determine coverage and payment available to the Member after subtracting the amounts that Medicare would pay.

COORDINATION OF BENEFITS (COB)

When Does Coordination of Benefits Apply?

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

Definitions

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

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

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

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

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

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

Primary Plan - the Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its Policy terms without consideration that another Plan may cover some expenses.
Secondary Plan- the Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Amount.
Order of Benefit Determination Rules
The order of benefit determination rules decides which Plan is Primary or Secondary when the Covered Person has health care coverage under more than one Plan.
When this Plan is primary, it determines payment for its benefits first. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Amount.

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

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

B. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

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

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan. The Plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
2. **Dependent Child Covered Under More Than One Coverage Plan**. Unless there is a court decree stating otherwise, plans covering a Dependent child shall determine the order of benefits as follows:
    a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
        (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
        (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
    b) For a Dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
        (1) If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the Dependent child's health care expenses, but that parent's spouse, Domestic Partner or legal partner does, that parent's spouse's, Domestic Partner's or legal partner's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
        (2) If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
        (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
        (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            a) The Plan covering the Custodial Parent.
            b) The Plan covering the Custodial Parent's spouse, domestic partner or legal partner.
            c) The Plan covering the non-Custodial Parent.
            d) The Plan covering the non-Custodial Parent's spouse, domestic partner or legal partner.

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

d) (i) For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a Dependent under a spouse's plan, the rule in paragraph (2) applies.

(ii) In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the Dependent child's parent(s) and the Dependent's spouse.

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

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

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

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

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:

- Employer's liability policies
- Municipal, state or federal law
- Occupational disease laws
- 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 Utah Department of Labor, if necessary.

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

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

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

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

SUBROGATION AND REIMBURSEMENT

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

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

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

You agree as follows:

- You will cooperate with Us in protecting Our right to reimbursement, including, but not limited to:
  - Providing any relevant information requested by Us.
  - Signing and/or delivering such documents as We or Our agents reasonably request to secure the reimbursement claim.

    - Responding to requests for information about any accident or injuries, and making court appearances, and
    - Obtaining Our consent or Our agent's consent before releasing any party from liability or payment of medical expenses.
- Failure to cooperate in this manner shall be deemed a breach of contract and may result in the instigation of legal action against You.
- We have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- Benefits paid by Us may also be considered to be Benefits advanced.
- You will seek Our approval of any settlement that does not fully compensate or reimburse You and Us, and You will not do anything to prejudice Our rights under this provision.
- If You do not file a claim, You will assign to Us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits We provided, plus reasonable costs of collection.
- if You do not file a claim, We may take necessary and appropriate action to preserve Our rights under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay You part of any recovery We might obtain.
- We will not be obligated in any way to pursue this right independently or on Your behalf.
- In the case of Your wrongful death, the provisions of this section will apply to Your estate, the personal representative of Your estate, and Your heirs.
- The provisions of this section apply to the parents, guardian, or other representative of a Child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a Child's Injury, the terms of this reimbursement clause shall apply to that claim.

REFUND OF OVERPAYMENTS

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

- Within 12 months for payments or overpayments made in error.
- Within 24 months for payments or overpayments made due to a coordination of benefits error
- Within 36 months for overpayments due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program.

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

GRACE PERIOD

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

LIMITATION OF LEGAL ACTION

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished. By enrolling in this health Benefit plan, You have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy that, on its effective date, conflicts with the statutes of the State of Utah is hereby amended to conform to the minimum requirements of such statutes. Any and all provisions of this agreement remain in full force and effect.

FRAUDULENT INSURANCE ACTS NOTICE

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. We reserve the right to recoup any Benefit payments paid on Your behalf, and/or to rescind the coverage under this Policy retroactively as if it never existed if You have committed fraud or intentional misrepresentation of material fact in applying for coverage in or receiving or filing for Benefits.

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 Utah Department of Insurance.

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

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

INSURANCE FRAUD INVESTIGATION UNIT AND CRIMINAL PREVENTION ACT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or Benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

TIME LIMIT ON CERTAIN DEFENSES

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

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

NOTICES

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

OTHER INFORMATION YOU SHOULD HAVE

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

On its effective date this Policy replaces and overrules any Policy that We may have previously issued to You. Any Policy We issue to You in the future will in turn overrule this Policy. This Policy will take effect on the date specified in this Policy. Coverage under this Policy will begin at 12:01

a.m. and end at 12:00 midnight Mountain 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 Utah. To the extent that state law applies, the laws of the State of Utah 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 the termination of Your coverage, except if such termination is the result of fraud or intentional misrepresentation of material fact.

- You are actively enrolled under more than one of Our Individual or Child-Only plans. Coverage under the first plan will end as of the effective date of any subsequent Bright HealthCare non-group plan.
- We decide not to renew all of Our Individual or Child-Only plans in the State of Utah. 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 ninety (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 intellectual or physical disability and is chiefly dependent upon the policyholder for support and maintenance, the Dependent can remain as a Dependent Child under the Policy. Proof of such dependency may be required within 31 days of the child's attainment of the limiting age, but not more frequently than annually after the initial two-year period following attainment of the limiting age.
- The spousal relationship, as noted in the *Definitions* section, 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 26. Coverage for the Covered Person reaching age 26 will end on the last day of the month in which the Covered Person reaches age 26.
- The Subscriber's death. Upon the death of the Subscriber, Dependent coverage may be continued under a new Policy with a new ID number. Contact Customer Service at the number on Your ID Card for additional information.
- Coverage will end if Premiums are not paid when they are due. A grace period of three months for individuals receiving federal insurance subsidies will be allowed for the payment of all outstanding Premiums. If the full balance of outstanding Premium is not paid within the grace period, coverage will end on the last day of the first calendar month of the grace period. For non-subsidized Members, a 31-day grace period will be allowed for the payment of all outstanding Premiums. If the full balance of outstanding Premium is not paid within the grace period, coverage will end on the last day for which You have paid Your

Premium. We will provide You notice of Your nonpayment before cancelling Your Policy. We will not pay for any services received on or after the date Your coverage ends.

- 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 written notice thirty (30) days prior to rescinding coverage.

REINSTATEMENT OF COVERAGE

If any Premium is not paid within the time granted to You for payment, a subsequent acceptance of Premium by Us, without requiring an application for reinstatement, shall reinstate the Policy. This is provided, however, that if We require an application for reinstatement and issue a conditional receipt for the Premium paid, the Policy will be reinstated upon approval of application by Us or, lacking such approval, upon the 45th day following the date of the conditional receipt unless We have previously notified You in writing of Our disapproval of Your application. The reinstated Policy shall cover only loss resulting from Accidental Injuries sustained after the date of reinstatement and loss due to Illnesses. In all other respects You and We 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 60 days prior to the date of reinstatement.

Section 12 – Appeals and Complaints

CULTURAL AND LINGUISTIC HANDLING OF DENIALS AND APPEALS

We are required to provide culturally and linguistically appropriate notices, which means that We will provide the following:

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

WHAT TO DO IF YOU HAVE A QUESTION

Contact Customer Service at the telephone number listed in Section 2 of this Policy and on Your ID Card. Customer Service representatives are available to take Your call and resolve Your inquiry.

WHAT TO DO IF YOU HAVE A COMPLAINT

Contact Customer Service at the telephone number listed in Section 2 of this Policy and on Your ID Card. Customer Service representatives are available to take Your call.

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

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

APPEAL OF AN ADVERSE DETERMINATION

If You disagree with an Adverse Determination and wish to appeal, You may request a review of the Adverse Determination. We have an internal review process.

INTERNAL REVIEW PROCESS

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

Your request for an appeal must include:

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

Appeal Review Process

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

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

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

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

Notice of Appeal Determination
Within thirty (30) days of receipt, We will provide You with a written notice of Our determination along with a detailed explanation of the basis for that determination.

EXPEDITED APPEALS

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

An expedited appeal request does not need to be submitted in writing. An expedited review may be requested by calling Us directly at the Customer Service number listed in Section 2 of this Policy and on Your ID Card.

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

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

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

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

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

Independent Review Process

- **We will pay the cost of the Independent Review Organization for conducting the independent review.**
- **An independent review is available to the claimant regardless of the dollar amount of the claim involved.**
- **The claimant shall have 180 calendar days after the receipt of a notice of a final adverse benefit determination to file a request with the commissioner for an independent review.**
- **The claimant shall use the Independent Review Request Form available on Utah website at www.utah.gov, or a substantially similar form, to file the request.**

- **A request for an independent review sent to the carrier instead of the commissioner shall be forwarded to the commissioner by the carrier within one business day of receipt.**
- **The independent review decision is binding on the carrier and claimant except to the extent that other remedies are available under federal or state law.**

Important Notice – Claims Disputes
Should a dispute concerning a claim arise, call Us at the phone number listed in Section 2 of this Policy and on Your ID Card. If the dispute is not resolved, You may contact the Utah Insurance Department at (801) 957-9280, https://insurance.utah.gov, or:

Utah Insurance Department

4315 S 2700 W
Suite 2300
Taylorsville, UT 84129

Section 13 – Policy and Rate Changes

CHANGES TO THIS POLICY

We may change Your Policy by adding Amendments. Amendments are legal documents that change certain parts of the Policy. If we make a change, we must notify You at least 60 days before 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. A notice of change in premium shall be given no fewer than 45 days before the renewal date. Premiums will not change more than once a year unless there is a change to who is enrolled, You choose a different plan during a Special Enrollment Period, or if You move.

MISSTATEMENT OF AGE

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

ADDRESS CHANGES

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

RENEWAL OF POLICY

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

Section 14 – Definitions

Adverse Determination means:

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

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

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

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

Ancillary Provider - a Provider whose services may include anesthesiology, pathology, Hospital or Facility Physician services, radiology, physical, speech, and occupational therapies rendered in a Facility setting, and ambulance services.

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

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

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

Autism Spectrum Disorders - Pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
Benefits - Your right to payment for Covered Health Services that are available under this Policy. Your right to Benefits is subject to the terms, conditions, limitations, and exclusions of this Policy, which includes the Schedule of Benefits along with any attached Amendments.

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

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

Centers of Excellence – a facility that provides best practices, leadership, research and support for a specific focus of care.

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

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

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

A Child will be eligible to continue dependent coverage through the last day of the month in which they cease to be an eligible dependent by turning age 26.

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

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

Child-Only Policy – a Policy for which coverage is provided for Children under age 26, without a parent or legal guardian enrolling.

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

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

Complications of Pregnancy - are conditions (when the Pregnancy is not terminated), whose diagnoses are distinct from the Pregnancy, but are adversely affected by the Pregnancy or caused by the Pregnancy, including, but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also include non-elective cesarean section, termination of ectopic Pregnancy, and spontaneous termination of Pregnancy, which occurs during a period of gestation in which a viable birth is not possible, Complications of Pregnancy do not include false labor, occasional spotting, morning Sickness, Physician prescribed rest during the period of Pregnancy, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult Pregnancy not constituting a distinct complication of Pregnancy.

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

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

Congenital Anomaly - a physical developmental defect that is not limited to the time of birth.

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

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

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

- Unless otherwise specified, are provided for the purpose of diagnosing or treating a Sickness, Injury, or associated symptoms.
- Consistent with nationally recognized Scientific Evidence as available, and Prevailing Medical Standards and Clinical Guidelines.
- Not provided for the convenience of the Covered Person, Physician, Facility, or any other person.
- Described in the *Benefits/Coverages (What is Covered)* and *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 Use Disorder symptoms. This treatment is typically 3 days or less, but may be longer when Medically Necessary and appropriate.

Custodial Care - services that are any of the following:

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

Days' Supply Limit – This is the number of days of therapy You 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.

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

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

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

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

Disabled Dependent - a child who is unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and chiefly dependent upon an insured for support and maintenance since the child reached the age of 26.

Domestic Partner – an unmarried partner of the same or opposite sex involved in a committed, interpersonal relationship sharing their domestic life as if married.

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

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

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

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

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

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

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

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

Experimental, Investigational Service or Unproven Service(s) - medical treatment, services, supplies, medications, drugs, or other methods of therapy or medical practices, which are not

accepted as a valid course of treatment by the Utah Medical Association, the U.S. Food and Drug Administration, the American Medical Association, or the Surgeon General.

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

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

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

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

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

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

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

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

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

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

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

- Eosinophilic disorders as evidenced by the results of a biopsy
- Glutaric acidemias
- Histidinemia
- Homocystinuria
- Hyperlysinemia
- Immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins

- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract
- Maple syrup urine disease
- Maternal phenylketonuria in female Covered Persons of Childbearing age who are less than 35 years of age
- Methylmalonic ademia
- Phenylketonuria in Covered Persons who are less than 21 years of age
- Proprionic academia
- Severe food protein induced enterocolitis syndrome
- Tyrosinemia
- Urea cycle disorders

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

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

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

Intermediate Care - Mental Health/and Substance 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:
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.
    - 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 three hours but not more than 12 hours in any 24-hour 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 (e.g., less than four hours per day) partial Hospital programs.

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

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

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

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

Maximum Allowable Cost (MAC)/Maximum Reimbursement Amount List - a list of Generic Prescription Drug Products along with established prices that Our Pharmacy Services Vendor has created. The list is maintained by Our Pharmacy Services Vendor and We use a list to price most

of the Generic medications available under this benefit. This list is subject to periodic review and modification.

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

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

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

Medically Necessary/Medical Necessity – health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
(a) health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

(i) in accordance with generally accepted standards of medical practice in the United States;
(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;
(iii) not primarily for the convenience of the patient, physician, or other health care provider; and
(iv) covered under the contract;

(b) when a medical question-of-fact exists, medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(i) For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence.
(ii) For established interventions, the effectiveness shall be based on:
(A) scientific evidence;
(B) professional standards; and

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

Mental Health Disorder or Mental Illness – Conditions as described in the current *Diagnostic and Statistical Manual* of the American Psychiatric Association, including but not limited to: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder, trauma and stressor related disorders or post-traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, anorexia nervosa, bulimia nervosa, anxiety disorders, neurodevelopmental disorders, or other intellectual disabilities. For the purpose of this coverage, Mental Disorder may also include other diagnoses made by an appropriately licensed health professional and/or approved by Us.

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

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

Network Pharmacy - a pharmacy that has:

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

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

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

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

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

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

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

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

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

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

Refer to the *Schedule of Benefits (Who Pays What)* section of this Policy for details about how the Out-of-Pocket Maximum applies.

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

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

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

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

Plan Year – is a traditional calendar year. If Your initial effective date is other than January 1, Your initial Plan Year will be less than 12 months, beginning on Your actual effective date and running through December 31 of that same year.

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

- This Policy, which includes the Schedule of Benefits
- 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.

Pregnancy - includes all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sickness - illness, disease, or disorder of an insured person.

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

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

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

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

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

Substance Abuse Services - covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* unless those services are specifically excluded.

The fact that a disorder is listed in *the Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Telemedicine - the delivery of medical services and diagnosis, consultation, or treatment using interactive audio, interactive video, or interactive data communication. Telemedicine visits are considered office visits and the applicable office visit Copayment, Coinsurance and/or Deductible applies.

Therapeutically Equivalent - when Prescription Drug Products can be expected to produce essentially the same therapeutic outcome and toxicity.

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

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

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

In December of 2020, the No Surprises Act was signed into law as part of the Consolidated Appropriations Act of 2021. The No Surprises Act impacts how Providers and insurance companies can work together to help patients understand their costs for medical care, and gives Providers and insurance companies guidance on resolving disputes around reimbursement. Most sections of the legislation go into effect on January 1, 2022. This summary of the No Surprises Act describes the provisions of the Act that affect You as a Member of Bright HealthCare. You can review the Act at: https://rules.house.gov/sites/democrats.rules.house.gov/files/BILLS-116HR133SA-RCP-116-68.pdf.

SEC. 102. HEALTH INSURANCE REQUIREMENTS REGARDING SURPRISE MEDICAL BILLING

Health Insurance Requirements for Emergency Services

We will cover emergency services without imposing Prior Authorization requirements and regardless of whether the Provider is in Our network. Services will be covered at the same cost-share amount whether received from a Network or Non-Network Provider.

We will pay or issue a notice of payment denial to the Provider within thirty (30) calendar days after receiving the bill for the services. We must reimburse the Provider directly and cannot route payment through the patient. Any patient cost-sharing must count toward the patient's deductible and/or out-of-pocket cost-sharing maximum as though the services were provided in-network.

Patient Access to Pediatric, Obstetrical and Gynecological Care

Pediatricians may serve as a child's primary care Provider. Additionally, You are able to access obstetrical and gynecological care without having to go through an approval process such as a referral or Prior Authorization.

SEC. 103. DETERMINATION OF OUT-OF-NETWORK RATES TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE RESOLUTION PROCESS

Reimbursement for Non-Network services may be determined in one of several ways. State law or policy should be followed. If no such policy applies, the following process should be followed in accordance with the legislation. First, the Provider may accept the initial payment made by Us. Second, Bright HealthCare and the Provider may come to a mutually agreeable amount through routine negotiating procedures during a thirty (30) day period beginning the day the Provider receives the initial payment (or payment denial) from Us. Finally, should either of these processes fail, the parties may bring an outstanding dispute to an Independent Dispute Resolution (IDR) process as established under the law. The parties can continue to negotiate during the IDR process and do not need to complete the IDR process if agreement for reimbursement can be reached during this period.

SEC. 104. HEALTH CARE PROVIDER REQUIREMENTS REGARDING SURPRISE MEDICAL BILLING

Non-Network health care Providers (including facilities, physicians and non-physician practitioners) may not balance bill patients for covered emergency services or certain covered non-emergency services provided at Network facilities unless certain conditions are met. In other words, the cost You pay for these services must be limited to no more than what You would have paid if the Provider been In-Network.

Notice and Consent Process and Requirements

A Non-network Provider may balance bill a patient for items or services if they satisfy the notice and consent process established under the law. However, the notice and consent process may not be used for certain services, including emergency services, certain ancillary services, and items or services that are delivered as a result of an unforeseen urgent medical need that arises during a procedure for which notice and consent was received.

Written notice and consent must be received within seventy-two (72) hours of the item or service being delivered or, if the item or service is scheduled within that timeframe, at the time the appointment is made. The notice can be in paper or electronic form (as selected by the patient) and must contain the following information at a minimum:

- notification that the Provider is not in Our Network;
- a good faith estimate of the charges;
- a list of Network Providers at the facility (if the facility is in-network) to which the patient can be referred;
- information on any prior authorization or other care management requirements; and
- a clear statement that consent is optional and the patient can instead opt for a Network Provider.

Ancillary Services for Which Notice and Consent Option Does Not Apply
Patients receiving the following nonemergency ancillary services may not be billed beyond their in-network cost-sharing amount:

- emergency medicine,
- anesthesiology,
- pathology,
- radiology, and
- neonatology, as well as diagnostic services (including radiology and laboratory services).

In addition, a Non-Network Provider cannot use the notice and consent process if there is not a Network Provider available to furnish the item or service at the facility.

SEC. 105. ENDING SURPRISE AIR AMBULANCE BILLS
Patients using air ambulance services (defined as medical transport using helicopter or airplane) have similar consumer protections against surprise medical billing for emergency services. You are required to pay only the Network cost-sharing amount for Non-Network air ambulances and those amounts will count toward Your deductible. Non-Network air ambulance Providers are not allowed to balance bill patients for more than the Network cost-sharing amount.

SEC. 107. TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS
Your member ID Card shall contain the following information:

- All plan deductibles, including Network and Non-Network deductible amounts, as applicable.
- Maximum limits on out-of-pocket costs, including Network and Non-Network out-of-pocket cost limits, as applicable.
- A telephone number and web address for consumer assistance information, including information on Network Providers.

SEC. 108. IMPLEMENTING PROTECTIONS AGAINST PROVIDER DISCRIMINATION
With respect to Providers participating in Our Provider Network, We shall not discriminate against any Provider who is acting within the scope of their license or certification under applicable state law. Health plans are not required under this section of the PHS Act to contract with any willing health care Provider nor does this section prevent health plans or HHS from establishing varying reimbursement rates based on quality or performance measures.

SEC. 110. CONSUMER PROTECTIONS THROUGH APPLICATION OF HEALTH PLAN EXTERNAL REVIEW IN CASES OF CERTAIN SURPRISE MEDICAL BILLS
There is an external review process in place to determine whether We have correctly determined when the surprise medical billing protections do not apply.

SEC. 111. CONSUMER PROTECTIONS THROUGH HEALTH PLAN REQUIREMENT FOR FAIR AND HONEST ADVANCE COST ESTIMATE
We must send an "Advanced Explanations of Benefits" (EOB) prior to scheduled care or upon request by patients seeking more information prior to scheduling.

The Advanced EOB requirement is triggered by the Provider sending Us a "good faith estimate," as required in Section 112. A patient also may request an Advanced EOB from Us. The Advanced EOB must include:

- Information on whether the Provider or facility delivering the item or service are in-network for that particular item or service.
    - If for a Network Provider or facility, We must include the contracted rate for the item or service, based on the billing and diagnostic codes sent by the Provider.
    - If the Provider or facility is Non-Network, we must include a description of how the patient could obtain information on Network Providers delivering that item or service.
- The "good faith estimate" of expected charges, including likely billing and diagnostic codes, sent by the Provider or facility.
- A "good faith estimate" of Our payment responsibility.
- A "good faith estimate" of the patient's expected cost-sharing amount (based on the notification date and not the date of service).
- A "good faith estimate" of the amount the patient has incurred toward meeting their financial responsibility limits, such as their deductible and out-of-pocket maximums.
- A disclaimer that coverage for the item or service is subject to a medical management, such as Prior Authorization, as appropriate.
- A disclaimer that all information included in the notice is an estimate based on the information known at the time of scheduling or requesting the information and is subject to change.
- Any other information or disclaimers the health plans determine is appropriate for this notice.

We must share this information with You by mail or electronically based on patient preference within three (3) business days of receiving a request or notice that a service had been scheduled, as long as the service is scheduled for at least ten (10) business days after the notice. If the services are scheduled for less than ten (10) days after the notice, We must provide this information within one (1) business day. *The HHS Secretary will have the authority to modify the timing requirements for services deemed to have low utilization or significant variations in costs.*

SEC. 112. PATIENT PROTECTIONS THROUGH TRANSPARENCY AND PATIENT-PROVIDER DISPUTE RESOLUTION

Health care Providers (both individual practitioners and facilities) must share "good faith estimates" of the total expected charges for scheduled items or services, including any expected ancillary services, with Us (if the patient is insured) or with the patient (if the patient is uninsured). The notice shall include the expected billing and diagnostic codes for all items and services to be provided. This requirement applies whenever items or services are scheduled at least three (3) days in advance or when requested by a patient. The Provider will need to determine the patient's health coverage status and develop the "good faith estimate" at least three (3) business days before the service is furnished and no later than one (1) business day after scheduling, unless the service is scheduled for more than ten (10) business days later. In those instances, the Provider will need to furnish the information within three (3) business days of a patient requesting an estimate or scheduling a service.

In the event of a dispute, the patient-provider dispute resolution process established by HHS will be followed to adjudicate any disputes over pricing for uninsured patients that receive a substantially higher bill than the "good faith estimate" provided prior to service.

SEC. 113. ENSURING CONTINUITY OF CARE

If there is a change to Our Provider Network, You may be eligible for Continuity of Care. Continuity of Care is available to patients who are undergoing a course of treatment for a serious or complex condition, undergoing institutional or inpatient care, scheduled to undergo non-elective surgery including post-operative care, pregnant and undergoing treatment, or terminally ill and receiving services. Plans are required to ensure continuing care patients receive timely notification of changes in the network status of Providers and facilities. Such patients will have up to ninety (90) days of continued coverage at in-network cost sharing to allow for a transition of care to a Network Provider.

Refer to Section 5 of Your Policy for additional information about Continuity of Care.

SEC. 114. MAINTENANCE OF PRICE COMPARISON TOOL

We maintain online price comparison tools that allow patients to compare expected out-of-pocket costs for items and services across multiple Providers. We can also provide price comparisons over the phone. Health plans will need to offer such price comparisons for plan years beginning on or after Jan. 1, 2022.

SEC. 116. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION

We have established a verification process to ensure accurate Provider Directories, a response protocol for individuals inquiring about the network status of a Provider, and a publicly accessible Provider database. These Provider directory requirements do not pre-empt existing state law, and patients that relied on inaccurate Provider directory information would only be subject to the in-network cost sharing amounts. We must verify and update Provider Directory information no less than every ninety (90) days (or within two (2) days of receiving notice of a change.

We are required to respond to persons inquiring about the network status of a Provider or facility within one (1) business day of the inquiry and must retain records of the inquiry for two (2) years. We must have a web-based Provider directory that includes the Provider and facility contact information, specialty information, direct or indirect contractual relationship with Us, and digital contact information. We also make information about balance-billing protections available on Our website and through other communications. Where applicable by state law, We must provide information regarding allowable charges by non-contracting Providers or facilities and any consumer cost-sharing obligations.

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 Your Policy and on Your ID card to obtain a copy of Our Provider Directory.