



# 2022

## Certificate of Coverage

## **Section 1 – Title Page (Cover Page)**

### **Individual Evidence of Coverage (“EOC”)**

**This Consumer Choice of Benefits health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this EOC.**

This document includes important information that describes Your EOC. Your EOC is a legal contract between the Subscriber and Bright HealthCare Insurance Company of Texas (“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 EOC is issued when We receive the application and in consideration of any and all required payment(s).

#### **ENTIRE CONTRACT**

This EOC includes Your:

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

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

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

#### **HOW TO USE THIS DOCUMENT**

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

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

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

#### **RIGHT TO CANCEL OR RETURN THIS EOC**

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.

#### **INFORMATION ABOUT DEFINED TERMS**

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

When You see the words “We,” “Us,” and “Our,” We are referring to Bright Health. When You see the words “You” and “Your,” We are referring to Covered Persons. If the Covered Person is under age 18, “You” and “Your” refer to the Responsible Adult.

**BRIGHT HEALTH**  
**Toll Free – (844) 926-4524**  
**P.O. Box 1519**  
**Portland, ME 04104**  
**[www.brighthealthcare.com](http://www.brighthealthcare.com)**

A handwritten signature in black ink, appearing to read 'Simeon Schindelman', with a long horizontal flourish extending to the right.

Simeon Schindelman  
Chief Executive Officer

## Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

### **Bright HealthCare Insurance Company of Texas**

To get information or file a complaint with your insurance company or HMO:

**Call: Customer Service at (844) 926-4524, Toll-free: (844) 926-4524**

Online: [www.brighthealthcare.com](http://www.brighthealthcare.com)

Mail: P.O. Box 1519  
Portland, ME 04104

### **The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

## ¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

### **Bright HealthCare Insurance Company of Texas**

Para obtener información o para presentar una queja ante su compañía de seguros o

**Llame a: Customer Service al (844) 926-4523**

**Teléfono gratuito: (844) 926-4523**

En línea: [www.brighthealthcare.com](http://www.brighthealthcare.com)

Dirección postal: P.O. Box 1519  
Portland, ME 04104

### **El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

## **THIS IS A HEALTH MAINTENANCE ORGANIZATION (“HMO”) PLAN**

A health maintenance organization (“HMO”) plan provides no benefits for services You receive from out-of-network physicians or providers, with specific exceptions as described in Your Evidence of Coverage and below.

You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers).

If you believe that the network is inadequate, You may file a complaint with the Texas Department of Insurance at:  
[www.tdi.texas.gov/consumer/complfrm.html](http://www.tdi.texas.gov/consumer/complfrm.html).

If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if You have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician’s or provider’s bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.

You can obtain a current directory of network physicians and providers at the following website: [www.brighthealthcare.com](http://www.brighthealthcare.com), or by calling Bright HealthCare Customer Service at (844) 926-4524 for assistance in finding available network physicians and providers. If You relied on materially inaccurate directory information, You may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider if you present a copy of the inaccurate directory information to the HMO, dated not more than thirty (30) days before You received the service.

## Section 2 – Contact Us

Please contact Us for more information.

### Questions About Your Benefits

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

On Our Website at:  
[www.brighthealthcare.com](http://www.brighthealthcare.com)

### To Send Us Claims or Other Written Correspondence, Mail to:

Claim Submissions and Correspondence Address:

Bright Health Plan  
P.O. Box 1519  
Portland, ME 04104

## Nondiscrimination Notice and Assistance with Communication

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

## Language Assistance and Alternate Formats

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

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

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

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

**Bright Health Civil Rights Coordinator**  
P.O. Box 853943, Richardson, TX 75085-3943  
Phone: (844) 202-2154  
Email: [OAG@brighthealthcare.com](mailto: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 Member Services number on your Member ID card. You must send the complaint within 60 days of discovering the issue.

## MEMBER RIGHTS AND RESPONSIBILITIES

### You Have the Right to:

- Receive medical treatment that is available when You need it and is handled in a way that respects Your privacy and dignity.

- Get understandable information You need about Your health benefit plan, including information about services that are covered and not covered, and any costs that You will be responsible for paying.
- Obtain information about the qualifications of clinical staff that support Our wellness and similar programs.
- Have access to a current list of Network Physicians, Hospitals and places You can receive care, and information about a particular Physician's education, training, and practice.
- Select a primary care Physician for Yourself and each member of Your family who is enrolled, and to change Your primary care Physician for any reason. Although it is highly recommended that you select a primary care Physician, it is not required under this plan in order to receive Benefits.
- Have Your medical information kept confidential by Us and Your Physician. We honor the confidentiality of Covered Person information and adhere to all federal and state regulations regarding confidentiality and the protection of personal health information.
- Participate with Your health care professional in health care decisions and have Your health care professional give You information about Your medical condition and Your treatment options, regardless of coverage or cost. You have the right to receive this information in terms and language You understand.
- Learn about any care You receive. You should be made aware of any special programs or services that We have made available to assist You, as well as how to enroll, or change programs or services. You should be asked for Your consent for all care, unless there is an Emergency and Your life and health are in serious danger.
- Refuse medical care and disenroll from programs/services offered by Us. If You refuse medical care, Your health care professional should tell You what might happen. We urge You to discuss Your concerns about care with Your primary care Physician or other participating health care professional. Your Physician or health care professional will give You advice, but You will have the final decision.
- Be heard. Our complaint-handling process is designed to: hear and act on Your complaint or concern about Us and/or the quality of care You receive from health care professionals and the various places You receive care in our network; provide a courteous, prompt response; and guide You through Our appeal process if You do not agree with Our decision.
- Make recommendations regarding Our policies that affect Your rights and responsibilities.

**You Have the Responsibility to:**

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

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



## 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	אויפמערקזאמקייט: אייב איר רעדט יידיש, עס זענען פאראן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט די מעמבער סערוויסעס נומער אויף אייערע איידי קארטל.
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 المدون 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'anida'áwo' déé', t'áá jniik'eh, ná hóló. Kojì' hódííłnih Member Servicesjì éí binumber naaltsoos nítł'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.



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## Section 4 – Eligibility

We offer two types of Individual EOCs:

1. Individual EOCs: these EOCs include coverage for at least one adult age 19 or older and coverage for eligible Dependents.
2. Individual Child-Only EOCs: these EOCs include coverage for children under age 21, without a parent or legal guardian enrolling in the Plan.

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

### WHO IS ELIGIBLE FOR COVERAGE

#### Eligible Subscribers

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

- Reside, live, or work 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, except that an enrolled Dependent whose coverage by a Subscriber is required by a medical or dental support order, will receive coverage comparable to other Dependents covered by this EOC).
- 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 EOC 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 EOC 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 EOC, except in the case of a child-only EOC.
- Your Child(ren) as defined in the Definitions section of this EOC.

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 EOC.

### WHEN COVERAGE BEGINS

If you are a new Covered Person 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.

Coverage for new Covered Persons begin on the first of the month only.

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

### ENROLLING ELIGIBLE DEPENDENTS

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

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

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

A dependent newborn child is automatically covered for the first 31 days of life. If you wish to continue enrollment of the newborn beyond the 31<sup>st</sup> day, the newborn must meet the definition of an eligible Child, and you must enroll the newborn within 60 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 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 60 days from the date the child is placed in Your custody or the date of the final decree of adoption. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber is required to pay the full premium 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 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 and You were insured through a carrier other than Bright Health on the date you were admitted, Your prior carrier is responsible for payment of Covered Health Services for the Inpatient Stay through the date of discharge. Bright Health will pay for related Covered Health Services in accordance with the terms of the EOC, following discharge from the hospitalization. We will work with You to ensure a seamless transition of previously approved therapies or prescription medications.

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

## Section 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 document. Benefits are reimbursable as set forth in the Schedule of Benefits. Benefits are provided through contracts with Network Providers, who agree to hold Subscribers harmless for payment of the cost of covered health care services beyond those listed 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 EOC.

### 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
- Medically Necessary services that You need are not available from a Network Provider. You must receive authorization from Us prior to receiving care if you need non-emergency services from a Non-Network Provider because they are not available from a Participating Provider.

You can review Our provider network online at [www.brighthealthcare.com](http://www.brighthealthcare.com), or You can contact the Customer Service Department at the telephone number listed in Section 2 of this EOC and on Your ID card to obtain a copy of Our Provider Directory.

### CHOOSE YOUR PHYSICIAN

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](http://www.brighthealthcare.com) or You can contact *Customer Service* at the telephone number listed in *Section 2* of this *EOC* and on Your ID card to obtain a copy of Our Provider Directory.

Participating Providers are subject to a credentialing process in which either We or Our designees confirm public information about the Provider's licensure and other professional credentials. This process does not assure the quality of the Provider's services. Providers and facilities and are solely responsible for the care they deliver.

Before obtaining services, You should always verify whether or not the Provider is a Participating Provider. A provider's contracted status may change. You can verify if the provider is still in Our Network online at [www.brighthealthcare.com](http://www.brighthealthcare.com) or by calling *Customer Service* at the telephone number listed in Section 2 of this EOC and on Your ID card.

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

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

This plan allows You to:

- Choose from Our Network of Participating Providers and Hospitals for Your health care needs;



- Have direct access to eye care providers, mental health care providers, pediatricians, obstetrical or gynecological health care professionals. You do not need Pre-authorization from the plan or from any other person (including a primary care provider) in order to obtain access to mental health, obstetrical, or gynecological care from a health care professional in Our network who specializes in those types of services. The health care professional, however, may be required to comply with certain provisions related to 1) obtaining Pre-authorization 2) following a pre-approved treatment plan, and 3) following procedures for making referrals to other Participating Providers. For a list of participating health care professionals who specialize in eye care, mental health, and obstetrics or gynecology, visit Our website at [www.brighthealthcare.com](http://www.brighthealthcare.com) or call Our Customer Service line at the number listed in Section 2 of this EOC and on Your ID card. Take advantage of significant cost savings when You use doctors contracted with Us.

You are not required to select a Primary Care Physician (PCP), but We encourage You to do so. The PCP is available to supervise and coordinate Your health care within Our network. You do not need a Referral from a PCP to obtain treatment for Covered Health Services from a Specialist participating in Our network.

## **PROVIDER NETWORK**

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

Our credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

Before obtaining services, You should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling Customer Service. A directory of providers is available online at [www.brighthealthcare.com](http://www.brighthealthcare.com) or You may obtain a copy by calling Customer Service at the telephone number listed in Section 2 of this EOC 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.

## **CONTINUITY OF CARE (WHEN YOU WISH TO CONTINUE RECEIVING CARE FROM A NON-NETWORK PROVIDER)**

Continuity of Care allows you to receive services at In-Network coverage levels for specified medical and behavioral conditions for a defined period of time when your In-Network doctor, hospital, or Provider leaves our Network and there are reasons preventing immediate transfer of care to another Network Provider that they reasonably believe could cause harm to you. Your Provider apply for Continuity of Care within 30 days of your Network Provider leaving our Network. Requests will be reviewed within 10 days of receipt; organ transplant requests will take longer.

In the event a Covered Person is under the care of a Network Provider at the time such Provider stops participating in the Network and at the time of the Network Provider's termination, the Covered Person has special circumstances. Special circumstances" means a condition such that the treating physician or health care provider reasonably believes that discontinuing care could cause harm to the patient. Special circumstances shall be identified by the treating physician or health care provider, who must request that the patient be permitted to continue treatment under the physician's or provider's care and agree not to seek payment from the patient of any amounts for which the patient would not be responsible if the physician or provider were still an In-Network Provider. Special circumstances include a (1) disability, (2) acute condition, (3) life-threatening illness, (4) when a person is pregnant and undergoing a course of treatment for the pregnancy, (5) when a person is undergoing a course of treatment for a serious and complex condition from the provider or facility, (6) is undergoing a course of institutional or inpatient care from the provider

or facility, or (7) is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery. We will continue providing coverage for that Provider's services at the In-Network benefit level.

The continuity of coverage under this subsection will not extend for more than ninety (90) days.

For information on how to apply for Continuity of Care, contact Bright Health Plan Customer Service at the telephone number listed in Section 2 of this EOC 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 EOC 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.

### **RECEIVING NON-EMERGENT CARE FROM NON-NETWORK PROVIDERS**

Non-Network Providers are not contracted with Us. Except as described below, if You receive non-emergent services from a Non-Network Provider the non-emergent services will not be covered under this Plan. That means You will be responsible for the entire amount that the Non-Network Provider bills You for the services.

There are specific situations when this Plan will cover non-emergent services from Non-Network Providers. If You receive care at an In-Network Facility there is a possibility that some of the facility-based Providers may not be In-Network with Us. The Non-Network facility-based Provider will be paid at the usual and customary rate or otherwise agreed upon rate. If this occurs, You will not be responsible for any payments beyond the Copayment, Deductible, and Percentage Copayment amounts that You would have paid had You received the Covered Health Services from an In-Network Provider.

A Covered Health Service performed by, or a covered supply related to that Covered Health Service provided by, a Non-Network Provider that is a diagnostic imaging provider or laboratory service provider will also be reimbursed at the usual and customary rate or at an agreed rate if the Non-Network Provider performed the service in connection with a Covered Health Service performed by a Network Provider. If this occurs, You will not be responsible for any payments beyond the Copayment, Deductible, and Percentage Copayment amounts that You would have paid had You received the Covered Health Services from an In-Network Provider.

These Non-Network Providers may send You a balance-bill, which is a bill for the difference between the amount We pay the provider and the provider's billed charges. If You receive a balance-bill You should contact Us at (844) 924-4524. You may also contact the Consumer Protection Division of the Texas Department of Insurance at (800) 252-3439 with complaints regarding payment.

Non-emergent services from Non-Network Providers are also covered by the Plan when Medically Necessary Covered Health Care Services are not available through a Network Provider. We will authorize a referral to a Non-Network provider, upon the request of a Network Provider and within a reasonable period after receipt of reasonably requested documentation. The Non-Network Provider will be reimbursed at the usual and customary rate or at an agreed rate. Any such request for a referral will be reviewed by a provider of the same or similar specialty as the Non-Network Provider to whom a referral is requested. Failure to obtain authorization from Us of a referral to a Non-Network Provider prior to receiving services from a Non-Network Provider will result in such services not being covered under this Plan.

## **PAYMENT FOR CHARGES TO NON-NETWORK PROVIDERS**

If You receive authorization from Us to receive non-emergency care from a Non-Network Provider, You may be required to pay the charges in full to that Provider at the time of service. To be reimbursed for the charges You have paid, You will need to provide Us with an itemized bill.

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

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

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

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

## **RECEIVING EMERGENCY CARE FROM NETWORK PROVIDERS OR NETWORK FACILITIES**

When receiving Medically Necessary emergency care from a Participating or In-Network facility, You will be responsible for Your In-Network Copayment or Percentage Copayment 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 or at a Non-Network Facility, We will pay the Non-Network Provider or Non-Network Facility the usual and customary rate or at a rate agreed to by Us and the Non-Network Provider.

## **OUR REIMBURSEMENT POLICIES**

Your plan will be administered in accordance with the plan terms and Texas laws. We develop reimbursement policy guidelines in accordance with one or more of the following methodologies:

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

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

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

## **LIMITATIONS ON SELECTION OF PROVIDERS**

If We determine that You are using health care services in a harmful or abusive manner, or with harmful frequency, Your selection of Network Providers may be limited. If this happens, We may require You to select a single Network Physician to provide and coordinate all future Covered

Health Services. If You don't make a selection within 31 days of the date We notify You, We will select a single Network Physician for You. If You fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

## **SERVICE AREA**

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

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

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

Please see Our provider directory on Our website at [www.brighthealthcare.com](http://www.brighthealthcare.com) for a list of Network Providers in the Service Area or contact the Customer Service Department at the telephone number listed in Section 2 of this EOC and on Your ID card for assistance.

## **MEDICAL NECESSITY**

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

We define a service, procedure or intervention as Medically Necessary if it meets all of the following criteria:

- It is a health intervention for the purpose of treating a medical condition
- It is the most appropriate supply or level of service, considering potential benefits and harms to the patient
- It is known to be effective in improving health outcomes

We use the following types of information in making decisions about medical necessity:

- For new interventions, effectiveness is determined by scientific evidence
- For existing interventions, effectiveness is determined by:
  - Scientific evidence
  - Professional standards
  - Expert opinion, and
  - Consideration of cost-effectiveness compared to alternative interventions, including no intervention

## **SECOND OPINIONS**

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

## **PRE-AUTHORIZATION**

Pre-authorization is a determination by Us that health care services proposed to be provided to an Covered Person are Medically Necessary and appropriate. Pre-authorization may be required to make sure services are Medically Necessary. Please refer to Your Schedule of Benefits to see which service require Pre-Authorization. This information can also be obtained by visiting our website: [www.brighthealthcare.com](http://www.brighthealthcare.com)

**Who is responsible for obtaining Pre-authorization?**

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

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

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

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

**Failure to obtain the Pre-authorization prior to receiving care may result in services not being covered.**

The Pre-authorization review process requires the full cooperation of the requesting Physician in order for Us to evaluate all of the pertinent information and make a coverage determination. After receiving a Pre-authorization request, We must make Our decision within the following timeframes:

- 1 hour for requests involving post-stabilization treatment or a life-threatening condition;
- 24 hours for requests involving concurrent hospitalization care or an Covered Person who is inpatient in a health care facility at the time the services are proposed;
- 3 calendar days for all other requests.

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

**If You do not obtain the necessary Pre-authorization prior to scheduling services, those services will be denied as not being preauthorized.**

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

**Pre-authorization Renewal**

We will accept requests for renewal of an existing Pre-authorization beginning 60 days from the date that the existing Pre-authorization is set to expire. Upon receipt of a request for renewal of an existing Pre-authorization, we will to the extent practicable, review the request and issue a determination indicating whether the service is preauthorized before the existing authorization expires.

**Pre-authorization for Certain Services**

We will not require Pre-authorization for a particular service if, in the most recent six-month evaluation period for the Physician or other provider submitting the request for Pre-authorization, We have or would have approved not less than 90 percent of the Pre-authorization requests submitted by that Physician or other provider for the particular service.

**CARE MANAGEMENT**

When We receive a request for Pre-authorization of health care services, We may work with You to implement the Care Management process and to provide You with information about additional services that are available to You, such as disease management programs, health education, and patient advocacy.

All Care Management decisions are made by only qualified licensed professionals trained to assess the clinical information used to support Care Management decisions. Our Care Management

decision-making is based only on appropriateness of care and service and existence of coverage, and that there are no financial incentives that encourage decisions that result in underutilization. We do not reward practitioners, referring Physicians, or Care Management decision makers for issuing denials of coverage.

### **DECIDE WHAT SERVICES YOU SHOULD RECEIVE**

Care decisions are between You and Your health care provider. We do not make decisions about the kind of care You should or should not receive. 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 otherwise owed to You. The billing address used is based on the plan under which Your coverage is issued; therefore, it is important that You verify that Your provider has the correct billing information on file for Your plan.

### **MEMBER COST SHARING REQUIREMENTS**

Cost-sharing amounts include deductibles, Percentage Copayment, and copayments.. Depending on the type of care You receive, and where you receive care, Your cost-sharing amounts will differ.

**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.

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

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

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

All Deductible, Copayment, and Percentage Copayments 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 Percentage Copayments amounts for Covered Health Services received from a participating Bright Health Provider for the remainder of the Calendar Year.

For EOCs that provide coverage to two or more people, each Covered Person's Individual Out-of-Pocket Maximum applies to the Family Out-of-Pocket Maximum. Once a Covered Person has met his or her Out-of-Pocket Maximum, the Covered Person will have no further obligation to pay charges for in-Network Covered Health Services for the remainder of the Calendar Year. Once two (2) or more Covered Person's combined Out-of-Pocket expenses reach the Family Out-of-Pocket Maximum, Covered Persons under the Family EOC 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 EOC which includes the Schedule of Benefits and any Amendments.
- Make factual determinations related to Benefits.

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

We may delegate this discretionary authority to other persons or entities that provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time at Our discretion. In order to receive Benefits, You must cooperate with those service providers.

### EXPLANATION OF COVERED HEALTH SERVICES

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

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

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

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

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

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

### COVERED HEALTH SERVICES

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

#### Accidental Injury Dental Services

Outpatient Services, physician Home Visits and Office Services, Emergency Care and Urgent Care services received at an Urgent Care Center for dental work and oral surgery are covered if they

are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means services are requested within 60 days from the onset of injury and are performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

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

- Oral examinations
- X-rays
- Tests and laboratory examinations
- Restorations
- Prosthetic services
- Oral surgery
- Mandibular/Maxillary reconstruction
- Anesthesia

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

### **Acquired Brain Injury**

Covered Health Services incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition.

Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation; Neurobehavioral, Neuropsychological, Neurophysiological and Psychophysiological Testing and Treatment; Neurofeedback Therapy, Remediation, Post-Acute Transition Services and Community Reintegration Services, including Outpatient Day Treatment Services; or any other Post-Acute-Care Treatment Services are covered, if such services are Medically Necessary as a result of and related to an Acquired Brain Injury.

Treatment for an Acquired Brain Injury may be provided at a Hospital, an acute or post-acute rehabilitation Hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

- Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.
- Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

To ensure that appropriate Post-Acute-Care Treatment Service is provided, this Plan includes coverage for reasonable expenses related to periodic reevaluation of the care of a Covered Person who:

- Has incurred an Acquired Brain Injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment at a later date.

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

### **Allergy Testing**

Covered Health Services include Medically Necessary allergy testing on an outpatient basis.

### **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 Pre-Authorization.

### **Amino Acid-Based Elemental Formulas**

Covered Health Services include formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:

- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- Severe food protein-induced enterocolitis syndromes;
- Eosinophilic disorders, as evidenced by the results of biopsy; and
- Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

A Prescription Order from your Physician is required. Your cost will be no higher than those for prescription drugs or other medications covered under this EOC.

### **Autism Spectrum Disorders (ASD)**

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

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

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

### **Chemotherapy Services – Outpatient**

Covered Health Services under this section includes intravenous chemotherapy treatment received on an outpatient basis at a Hospital or Alternate Facility.

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

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

Benefits under this section include:

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

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

### **Chiropractic Care**

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

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

Chiropractic Care is limited to 35 habilitative and 35 rehabilitative visits per calendar year combined between speech, occupational, physical therapy and chiropractic care. Please refer to Section 7 – Limitations/Exclusions to see services that are excluded from Chiropractic Care.

### **Clinical Trials**

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

- The treating Physician recommends participation in the clinical trial after determining that participation in the clinical trial has the potential to provide a therapeutic health benefit to the Covered Person.
- The Covered Person suffers from a condition that is disabling, progressive, or life threatening.
- The clinical trial or study is approved under the September 19, 2000, Medicare national coverage decision regarding clinical trials, as amended.
- The patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice, and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner; and
- Prior to participation in a clinical trial or study, the Covered Person has signed a statement of consent indicating that the Covered Person has been informed of the procedure to be undertaken, alternative methods of treatment, the general nature, and extent of the risks associated with participation in the clinical trial or study.

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

The coverage does not include:

- Any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry
- Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device
- Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing, and other expenses that the Covered Person or person accompanying the Covered Person may incur
- An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the Covered Person
- Costs for the management of research relating to the clinical trial or study; or
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the Covered Person's health plan

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

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

- (A) Federally Funded Trials - The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - (i) The National Institutes of Health.
  - (ii) The Centers for Disease Control and Prevention.
  - (iii) The Agency for Health Care Research and Quality.
  - (iv) The Centers for Medicare & Medicaid Services.
  - (v) cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.
  - (vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - (vii) 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 (FDA).
- (C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

**"Routine patient care cost"** means all items and services that are a benefit under a health coverage plan that would be covered if:

- 1) The Covered Person was not involved in either the experimental or the control arms of a clinical trial; except the investigational item or service, itself
- 2) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient
- 3) Items and services customarily provided by the research sponsors free of charge for any Covered Person in the trial
- 4) Items or services that are typically provided absent a clinical trial
- 5) Items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and
- 6) Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

#### **Cosmetic, Reconstructive, or Plastic Surgery**

Covered Health Services include Cosmetic, Reconstructive, or Plastic Surgery that meets one of the below criteria or is otherwise deemed medically necessary. These services require Pre-authorization:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Covered Person; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect such as cleft lip or cleft palate; or
- Surgery performed on a Covered Person for the treatment or correction of a congenital defect other than conditions of the breast; or
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

#### **Diabetes Services**

Covered Health Services under this section includes diabetic supplies and equipment including:

- blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by blind individuals;

- insulin pumps and associated appurtenances; 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 Percentage Copayment. Any supplies used in conjunction with the insulin pump will be subject to the Durable Medical Equipment provision.
- Insulin pumps, both external and implantable, and associated appurtenances, which include:
  - batteries;
  - skin preparation items;
  - adhesive supplies;
  - infusion sets;
  - insulin cartridges;
  - durable and disposable devices to assist in the injection of insulin; and
  - other required disposable supplies
- repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
- insulin infusion devices;
- podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes;
- test strips for blood glucose monitors;
- visual reading and urine test strips and tablets which test for glucose, ketones and protein;
- lancets and lancet devices;
- insulin and insulin analogs;
- injection aids, including devices used to assist with insulin injection and needleless systems;
- insulin syringes;
- biohazard disposal containers
- prescription medications which bear the legend "Caution: Federal Law prohibits dispensing without a prescription" and medications available without a prescription for controlling the blood sugar level:
  - glucagon emergency kits
- As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies shall be covered if determined to be medically necessary and appropriate by a treating physician or other practitioner through a written order.
- All supplies including medications, and equipment for the control of diabetes shall be dispensed as written, including brand name products, unless substitution is approved by the physician or practitioner who issues the written order for the supplies or equipment.

Brands for these supplies may be determined at Our sole discretion.

This plan also covers:

- Outpatient self-management training, education, and medical nutrition therapy services ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.
- Medical eye examinations (dilated retinal examinations) for Covered Persons with diabetes.
- Preventive foot care for Covered Persons with diabetes.
- One pair of custom Diabetic shoes per calendar year..
- Diabetic shoes. Covered Health Services include one pair of custom shoes per calendar year as prescribed by a Physician in relation to the diagnosis of diabetes.

#### **Diabetes Services—Emergency Refills**

This plan covers emergency refills of the following diabetes equipment or diabetes supplies dispensed to the Covered Person by a pharmacist, pursuant to the exercise of the pharmacist's professional judgment and without the authorization of the prescribing Physician, in the same

manner as for a nonemergency refill of such diabetes equipment or diabetes supplies, if the pharmacist:

- (a) is unable to contact the prescribing Physician after reasonable effort;
- (b) is provided with documentation showing that the Covered Person was previously prescribed insulin or insulin-related equipment or supplies by a Physician;
- (c) assesses the Covered Person to determine whether the emergency refill is appropriate;
- (d) creates a record that documents the Covered Person's visit that includes notation describing the documentation provided showing that the Covered Person was previously prescribed insulin or insulin-related equipment or supplies by a Physician; and
- (e) makes a reasonable attempt to inform the prescribing Physician of the emergency refill at the earliest reasonable time.

The quantity of an emergency refill of insulin may not exceed a 30-day supply. The quantity of an emergency refill of insulin-related equipment or supplies may not exceed the lesser of a 30-day supply or the smallest available package.

For purposes of this section, "insulin" includes an insulin analog and an insulin-like medication, regardless of the activation period or whether the solution is mixed before the prescription is dispensed; and "insulin-related equipment or supplies" includes needles, syringes, cartridge systems, prefilled pen systems, glucose meters, continuous glucose monitor supplies, and test strips, but excludes insulin pumps.

#### **Dialysis Services - Outpatient**

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

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

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

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

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

#### **Durable Medical Equipment**

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

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

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

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

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

Examples of Durable Medical Equipment include:

- Blood pressure cuffs
- Equipment to assist mobility, such as a standard wheelchair, once every five years
- A standard Hospital-type bed, once every five years
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors, and masks)
- Delivery pumps for tube feedings
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage)
- Nebulizers and Peak Flow Meters. Coverage under this plan includes the purchase of one (1) nebulizer in a calendar year period, or one (1) rental per episode, and the purchase of (1) peak flow meter. We will determine if the nebulizer is purchased or rented. Charges are covered at 100% of the Allowed Amount and are not subject to the Annual Deductible, Copayment, or Percentage Copayment. Coverage is available for repairs and replacement, except that:
  - Coverage for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect. Established guidelines by Medicare are followed for the lifetime of DME. Equipment is expected to last at least five 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 DME solely for warranty expiration, or new and improved equipment becoming available is not covered. Duplicate or extra DME for the purpose of the Covered Person's comfort, convenience, or travel is not covered. DME Benefits do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

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

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

### **Early Childhood Intervention Services**

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

Early childhood intervention services must be received from a qualified early intervention services provider, and must be Medically Necessary.

The following services are excluded from coverage under this Benefit:

- Assistive technology, unless otherwise covered under this EOC
- Non-emergency medical transportation

- Respite care, and
- Service coordination, other than case management services.

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

Early childhood intervention services are limited to forty-five (45) visits per calendar year. However, We will not limit coverage to forty-five (45) visits per calendar year for Medically Necessary Covered Health Services provided in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention.

### **Emergency Health Services**

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

If You are admitted to a Non-Network facility through the emergency room, You, your Physician or Hospital must notify Us within 24 hours, or as soon as reasonably possible. Upon stabilization, We may move You by ambulance to the nearest appropriate Network or Participating facility.

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

### **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).

### **Formulas for the Treatment of Phenylketonuria (PKU) or Other Heritable Diseases**

Covered Health Services include dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases. Phenylketonuria (PKU) formulas and special food products are covered, and subject to the same deductibles, co-pays, and network providers as other prescription products, when used to treat PKU.

### **Gender Identity & Gender Transition Services**

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

### **Genetic Testing**

Covered Health Services under this section includes charges made for genetic testing that uses a proven testing method for the identification of genetically linked inheritable disease.

Genetic testing is covered only if:

- The Covered Person has symptoms or signs of a genetically linked inheritable disease.
- It has been determined that a Covered Person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically linked inheritable disease when the results will impact clinical outcome; or

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

### **Hearing Aids**

Coverage for the cost of a medically necessary hearing aid or cochlear implant and related services and supplies for a covered individual and includes: fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearings aids; any treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gain; and for a cochlear implant, an external speech processor and controller with necessary components replacement every three years; and is limited to one hearing aid in each ear every three years; and one cochlear implant in each ear with internal replacement as medically or audilogically necessary.

Hearing Aids are covered once in a 36-month period.

### **Hearing Screening and Exams**

Covered Health Services includes a screening test for hearing loss from birth through the date the child is thirty (30) days old, and Medically Necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.

Children may receive a preventive hearing exam once per calendar year, through age 17.

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

Covered Health Services under this section include CT scans, PET scans, MRI, MRA, nuclear medicine, or major diagnostic services received on an outpatient basis at a Hospital, Alternate Facility.

Coverage under this section includes charges for:

- The facility
- Supplies and equipment; and
- Physician services

### **Home Health Care**

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

- Ordered by a Physician
- Provided in Your home by a certified home health agency

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

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

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



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

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

Home health services are limited to sixty (60) 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 Your Mental Health and Substance Abuse - Outpatient benefit for information on grief counseling.

### **Hospital and Free-Standing Facility Services**

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

- A Hospital room with two (2) or more beds. If a private room is used, We will allow only up to the prevailing two-bed room rate, unless a private room is Medically Necessary
- Care in Special Care Units such as Intensive Care, Cardiac Care, Neonatal Care, when Medically Necessary
- Operating rooms, delivery rooms and special treatment rooms
- Ambulatory surgery services
- Rehabilitation and radiation therapy
- Inpatient physician care services including services performed, prescribed, or supervised by physicians or other health professionals
- Supplies and services such as laboratory, cardiology, pathology and radiology received while in the Hospital
- Drugs, medicines, biologicals, and oxygen provided during your stay
- Blood, whole blood, blood plasma, blood plasma expanders, blood derivatives and blood factors, blood transfusions including blood processing and storage costs and their administration
- General nursing care, and private duty nursing when Medically Necessary
- Inhalation therapy
- Anesthesia
- Meals and special diets when medically necessary
- Short-term rehabilitation therapy services in an acute hospital setting

**Infertility Services**

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

**Infusion Therapy Services – Outpatient**

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

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

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

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

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

**Inpatient Physician Care Services**

Covered health services include services performed, prescribed, or supervised by physicians or other health professionals, including diagnostic, therapeutic, medical, surgical, preventive. Referral, and consultative health care services.

**Inpatient Rehabilitative and Habilitative Services/Skilled Nursing**

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

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

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

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

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

Coverage is limited to twenty five (25) days per calendar year.

**Lab, X-Ray, and Diagnostic Services - Outpatient**

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

Coverage under this section includes charges for:

- The facility
- Supplies and equipment; and
- Physician services

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

**Mastectomy or Lymph Node Dissection**

Any Covered Person who has either a mastectomy or a lymph node dissection due to treatment of breast cancer, this plan will provide coverage for inpatient care for a minimum of:

- 48 hours following a mastectomy; and
- 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the Covered Person receiving the treatment and the attending Physician determine that a shorter period of inpatient care is appropriate.

We may not:

- deny any Covered Person eligibility or continued eligibility or fail to renew this Plan solely to avoid providing the minimum inpatient hours;
- provide money payments or rebates to encourage any Covered Person to accept less than the minimum inpatient hours;
- reduce or limit the amount paid to the attending Physician, or otherwise penalize the Physician, because the Physician required a Covered Person to receive the minimum inpatient hours; or
- provide financial or other incentives to the attending Physician to encourage the Physician to provide care that is less than the minimum hours.

**Coverage and/or Benefits for Reconstructive Surgery After Mastectomy**

Coverage and/or benefits are provided to each Covered Person for reconstructive surgery after mastectomy, including:

- All stages of the reconstruction of the breast on which mastectomy has been performed;
- Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
- Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the Covered Person and the attending Physician.

Deductibles, Percentage Copayment and copayment amounts will be the same as those applied to other similarly covered inpatient hospital services or medical/surgical expenses.

We may not:

- offer the Covered Person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above;
- condition, limit, or deny any Covered Person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or
- reduce or limit the amount paid to the Physician or Provider, nor otherwise penalize, or provide a financial incentive to induce the Physician or Provider to provide care to a Covered Person in a manner inconsistent with the coverage and/or benefits shown above.

**Medical Supplies and Disposable Items**

Covered Health Services under this section include disposable medical supplies suitable for use in the home.

Some Covered items may include:

- Ostomy Supplies
  - Pouches, face plates, and belts
  - Irrigation sleeves and bags
  - Skin barriers
- Catheter Supplies
- Tubing and connectors for delivery pumps
- Burn garments
- Supplies related to insulin pumps

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

**Mental Health and Substance Abuse Services – Inpatient and Intermediate**

Covered Health Services under this section include Mental Health and Substance Abuse Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Benefits include treatment of Mental Illness and Substance Abuse whether treatment is voluntary on the part of the Covered Person or court ordered as the result of contact with the criminal justice or legal system.

Medically Necessary Mental Health Care or treatment of Serious Mental Illness or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be Inpatient Hospital Expense.

Covered Health Services for Mental Health and Substance Abuse are provided under the same terms and conditions applicable to, and are not subject to any quantitative or nonquantitative treatment limits that are more restrictive than those imposed on, medical and surgical benefits.

**Mental Health and Substance Abuse Services – Outpatient**

Covered Health Services under this section include Mental Health and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Mental health, Substance Abuse, and chemical dependency evaluations and assessment
- Diagnosis
- Treatment planning
- Referral services
- Medication management
- Short-term individual, family, and group therapeutic services, including intensive outpatient therapy
- Crisis intervention
- Habilitative and Rehabilitative services

Benefits include the treatment of Mental Illness and Substance Abuse whether treatment is voluntary on the part of the Covered Person or court ordered as the result of contact with the criminal justice or legal system.

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

Covered Health Services for Mental Health and Substance Abuse are provided under the same terms and conditions applicable, and are not subject to any quantitative or nonquantitative treatment limits that are more restrictive than those imposed on, medical and surgical benefits.

There are no visit limitations for services related to, or for the treatment of Mental Health and/or Substance Abuse.

### **Outpatient Therapies - Rehabilitative and Habilitative Services**

#### Habilitative Services – Outpatient Therapy

Covered Health Services under this section include short-term outpatient Habilitative Services, limited to 35 visits combined between:

- Physical therapy
- Occupational therapy; and
- Speech therapy

#### Rehabilitative Services – Outpatient Therapy

Covered Health Services under this section include short-term outpatient Rehabilitative Services, limited to 35 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.

There are no visit limitations for services related to, or for the treatment of Mental Health and/or Substance Abuse. Review the Mental Health/Substance Abuse Services – Outpatient section of this EOC for additional information.

**Note:** We will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders.

### **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 Anesthesia**

Covered Health Services under this section include general anesthesia when rendered in a Hospital, outpatient surgical facility, or other licensed facility, and associated Hospital and facility charges for dental services when the person has a physical, mental, or medically compromising condition, has dental needs that would make local anesthesia ineffective because of anatomic variations, infection or allergy, or is extremely uncooperative, unmanageable, anxious or uncommunicative.

### **Pediatric Dental Care**

For the purposes of this Benefit, coverage is limited to Enrolled Children who are under 19 years of age. Pediatric Dental coverage ends the last day of the month in which the child turns age 19. The number and frequency of each of these services are limited. Refer to the Limitations/Exclusions section of this EOC for more information regarding Pediatric Dental Care.

We will not prevent a covered person from selecting the dentist of choice to furnish dental care services offered by the EOC or interfere with the selection of any dentist, provided the dental care services are within scope of the dentist's license.

Covered Health Services under this section include the following:

- Diagnostic and preventive procedures, which must include:
  - Oral exams and evaluations

- Full mouth, intra-oral, and panoramic x-rays
- Bitewing x-rays
- Routine cleanings
- Fluoride treatments
- Space maintainers
- Sealants; and
- Palliative treatment
- Basic restorative services, which must include:
  - Amalgam fillings
  - Resin and composite fillings
  - Crowns
  - Pin retention; and
  - Sedative fillings
- Oral surgery, consisting of extractions
- Endodontics, consisting of:
  - Surgical periodontal services; and
  - Root canal therapy
- Medically Necessary orthodontia and Medically Necessary prosthodontics

Implants, denture repair and realignment, dentures and bridges, non-Medically Necessary orthodontia, and periodontics are not covered under this benefit provision.

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

Pediatric Dental Care paid according to billed charges

### **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/brighthouse/en.T>

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

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), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Coverage under this section does not include medications that are typically available by Prescription Order or Refill at a pharmacy.

### **Physician Fees for Surgical and Medical Services**

Covered Health Services under this section include physician fees for surgical procedures and

other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

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

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

### **Physician's Services for Sickness and Injury**

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

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

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

Covered Health Services for Preventive Care provided in a Physician's office are described under Preventive Care Services.

### **Clinic Fees**

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

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

### **Pregnancy – Maternity Services**

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

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

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

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

**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. Coverage for congenital defects of a

newborn child; or coverage of administration of the newborn screening tests, including for the cost of a newborn screening test kit in the amount provided by the Department of State Health Services.

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

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

#### **Prescription Drugs**

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

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

#### Identification Card required for Prescription Services

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

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

#### Medication Synchronization Plan

A Medication Synchronization Plan synchronizes the filling or refilling of multiple prescriptions. The prescribing Provider, Pharmacist and Covered Person may jointly approve a medication synchronization Plan for medication to treat a Covered Person's chronic illness. We will cover medications dispensed in accordance with the dates established in the medication synchronization plan. We allow a Pharmacist or Pharmacy to override Our denial of coverage through Our medication synchronization Plan and will provide coverage for the medication if:

- The prescription for the medication is being refilled in accordance with the medication synchronization plan; and
- The reason for the denial is that the prescription is being refilled before the date established by Our general prescription refill guidelines.

We will prorate any Cost-Sharing amount charged for a prescription drug dispensed in a quantity that is less than a 30 days' supply if:

- The Pharmacy or prescribing Provider notifies Us that:
- The quantity dispensed is to synchronize the dates that the Pharmacy dispenses Your prescription drugs; and
- The synchronization of the dates is in the best interest of You; and
- You agree to the synchronization.



The proration will be based on the number of days' supply of the drug actually dispensed. We will not prorate any fee paid to the Pharmacy for dispensing the drug for which the Cost-Sharing amount was prorated.

#### Pharmacy Network

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

#### Specialty Pharmacy

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

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

#### Mail order medications / Network Benefits

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

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

#### Formulary List

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

We may periodically change the status of a medication on the Formulary. These changes may occur at your renewal date, and with a 60-day notice to You. Additionally, the status of a medication may change from brand to Generic. Brand name or Generic product status may impact Your costs and coverage under this benefit.

You may view the Formulary at Our website [www.brighthealthcare.com](http://www.brighthealthcare.com) or contact Our Pharmacy Customer Service at the number listed on Your ID Card to request a copy.

#### Quantity Limit or Supply Limits

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

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

In order to find out which medications have a Quantity Limit restriction, refer to the Formulary at [www.brighthousehealthcare.com](http://www.brighthousehealthcare.com).

#### Limitation on Selection of Pharmacies

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

#### Pre-Authorization

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

In order to find out which medications require Prior Authorization, refer to the Formulary at [www.brighthousehealthcare.com](http://www.brighthousehealthcare.com).

#### Step Therapy

Step Therapy encourages You to try less costly but just as effective drugs before the Plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the Plan may require you to try Drug A first. If Drug A does not work for you, the Plan will then cover Drug B. The requirement to try a different drug first is called Step Therapy.

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

In order to find out which medications require Step Therapy, refer to the Formulary at [www.brighthousehealthcare.com](http://www.brighthousehealthcare.com).

Your prescribing Provider may submit to Us a written request for an exception to the Step Therapy program. We will grant an exception if the prescribing Provider's written request states that the drug is required under the Step Therapy program:

- is contraindicated;
- will likely cause an adverse reaction in or physical or mental harm to the patient; or is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;
- the patient previously discontinued taking the drug required under the Step Therapy program, or another prescription drug in the same pharmacologic class or with the same mechanism of action as the required drug while covered under this Plan or another Plan because the drug was not effective or had a diminished effect or because of an adverse event;
- the drug required under the Step Therapy program is not in the best interest of the patient, based on clinical appropriateness, because the patient's use of the drug is expected to cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care; worsen a comorbid condition of the patient; decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or
- the drug that is subject to the Step Therapy program was prescribed for the patient's condition while covered under this Plan or a previous Plan and the patient is stable on the drug and the change in the patient's prescription drug regimen required by the step therapy protocol is expected to be ineffective or cause harm to the patient based on the known clinical characteristics of the patient and the known characteristics of the required prescription drug regimen

Step Therapy requirements do not apply to prescription drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions.

#### Exceptions

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

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

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

You and/or Your health care provider can ask the plan to make an "exception" to cover a medication or to remove the medication restrictions or limits. If We agree that the exception request is Medically Necessary and the exception is approved, the medication will be covered at either:

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

Examples of exceptions are:

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

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

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

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

#### Off-label Medications

Covered Health Services under this section include the off-label use of a medication for the treatment of a chronic, disabling, or life-threatening illness if the drug has been approved by the Food and Drug Administration for at least one indication.

To qualify for Off-Label use, the drug must also be recognized for the specific treatment for which the drug is being prescribed by one of the following four 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 EOC.

#### 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 Percentage Copayment percentage or the Copayment amount as is applied to an intravenously administered or an injected cancer medication prescribed for the same purpose. Orally administered anticancer medication shall be deemed Medically Necessary by the treating Physician for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent site, and duration and not primarily for the convenience of the Covered Person, Physician, or other health care provider.

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

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

#### Drug Tiers

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

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

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

#### Covered Medications and Products

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

- Coverage is limited to prescription products, prescribed by a legal prescriber. Prescription Medications are labeled as "Caution: Federal Law Prohibits Dispensing without a Prescription," "Rx Only," and/or where the State recognizes such products as requiring a prescription or mandates coverage as such
- Insulin is covered as a prescription product, along with syringes, and items required for monitoring diabetes treatment and testing strips, ketone urine test strips, lancets and related devices, pen delivery system for insulin administration, insulin syringes, visual aids to support the visually impaired with the proper dosing of insulin (except eyewear), Prescription Medications for treatment of diabetes (oral medications), glucagon. Cost-sharing for insulin included in the Formulary shall not exceed \$25.00 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription. Our Formulary includes at least one insulin from each therapeutic class
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins when a prescription is required for dispensing, to prevent or treat a specific medical condition
- Compounded medications are covered when dispensed by a network pharmacy and contain at least one prescription product for treatment of a covered condition, which has no commercially available prescription alternative. The Plan will only cover the formulary prescription ingredient. Any over the counter medications or ingredients included in the compound are not covered
- Phenylketonuria (PKU) formulas and special food products are covered, and subject to the same deductibles, co-pays, and network providers as other prescription products, when used to treat PKU
- Specialty Pharmaceutical medications, as defined by the plan when dispensed by our Specialty Pharmacy Network Supplier
- Contraceptives medications, devices, and various other products are covered for use as birth control
- Immunizations administered at a Network Pharmacy
- Medications prescribed to treat emergency medical conditions while traveling outside the United States.

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

### Prescription Eye Drop Refills

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

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

### 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 prescription and OTC preparations, two (2) per calendar year
- Breast cancer preventive medications, such as tamoxifen, raloxifene, or aromatase inhibitors, for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
- Contraceptives (Barrier/Diaphragms/Cervical caps, Hormonal, Emergency, Implantable, Intrauterine)
- Folic acid – Generic OTC and prescription products 0.4-0.8 mg for women planning or capable of pregnancy
- Iron Supplements – Generic OTC and prescription products for children ages 6 to 12 months who are at risk for iron deficiency anemia
- Low to moderate dose statin preventive medication for adults ages 40-75 with no history of cardiovascular disease for the prevention of cardiovascular disease events and mortality
- Oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient
- Smoking Cessation medications
- Any other preventive medication included in the A or B recommendations of the task force or as required by state or federal law. For a complete list of Preventive Care services, visit the USPSTF website:  
<http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations>

### Continuation of Coverage

We will offer at the contracted level and until the plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the drug formulary before the plan renewal date.

### Payments and Refills

We may not require you to make a payment for a prescription drug at the point of sale in an amount greater than the lesser of: the applicable copayment; the allowable claim amount for the prescription drug; or the amount you would pay for the drug if you purchased the drug without using a health benefit plan or any other source of drug benefits or discount.

### What You Must Pay

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

## Preventive and Wellness Services

Covered Health Services under this section include 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>

Additional Preventive and wellness services covered under this Plan are:

- Abdominal aortic aneurysm screening for men ages 65-75 years old and who have ever smoked
- Adult immunizations
- Aspirin preventive medication: initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not an increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years
- Bacteriuria screening with urine culture for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, if later
- Bone mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis for:
  - A postmenopausal woman not receiving estrogen replacement therapy; or
  - An individual with:
    - Vertebral abnormalities
    - primary hyperparathyroidism; or
    - a history of bone fractures; or
  - An individual who is:
    - Receiving long-term glucocorticoid therapy, or
    - being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
- Blood pressure screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment
- BRCA risk assessment testing for women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing
- Screening mammogram, every year, for women age 35 and older. Screening mammogram means a breast cancer screening by low-dose mammography, including 2D and 3D (breast tomosynthesis) for women with or without clinical breast examination
- Diagnostic imaging for women of any age. Diagnostic imaging means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate: (1) a subjective or objective abnormality detected by a physician or patient in a breast; (2) an abnormality seen by a physician on a screening mammogram; (3) an abnormality previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician; or (4) an individual with a personal history of breast cancer or dense breast tissue.
- Breast cancer preventive medications for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
- Breastfeeding counseling, comprehensive lactation support, breast pump and supplies during pregnancy and after birth to promote and support breastfeeding
- Cardiovascular disease early detection tests. One of the following non-invasive screening tests for atherosclerosis and abnormal artery structure and function every 5 years when performed by a laboratory that is certified by a recognized national organization. Tests include a computed tomography (CT) scan measuring coronary artery calcifications; or ultrasonography measuring carotid intima-media thickness and plaque. Tests are available to each Covered Person who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years

- of age and who is diabetic; or has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.
- Medically recognized diagnostic examination for the early detection of ovarian and cervical cancer every year for women aged 18 or older. Coverage includes at a minimum, a CA 125 blood test; a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus; and any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer.
  - Chlamydia screening in sexually active women age 24 years or younger, and in older women who are at increased risk for infection
  - Colorectal cancer screening for colorectal cancer starting at age 45 years. At home non-invasive stool DNA colorectal screening tests are subject to Medical Necessity and Pre-Authorization requirements. Coverage includes all colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future; and an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.
  - Dental caries prevention for infants up to children age 5 including the application of fluoride varnish to the primary teeth. The USPSTF recommends Primary Care Physicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient
  - Depression screening for major depressive disorder for adolescents age 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up
  - Depression screening for the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up
  - Diabetes screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity
  - Fall prevention exercise interventions to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls
  - Folic acid – Generic OTC and prescription products 0.4-0.8 mg for women planning or capable of pregnancy
  - Gestational diabetes mellitus screening in asymptomatic pregnant women after 24 weeks of gestation
  - Gonorrhea prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum
  - Gonorrhea screening in sexually active women age 24 years or younger, and in older women who are at increased risk for infection
  - Healthy diet and physical activity counseling for overweight or obese adults to prevent cardiovascular disease, including behavioral counseling interventions for adults with additional cardiovascular disease risk factors
  - Hearing screening exams for children through age 17.
  - Hemoglobinopathies screening for sickle cell disease in newborns
  - Hepatitis B screening in pregnant women at their first prenatal visit, and in nonpregnant adolescents and adults who are at high risk for infection
  - Hepatitis C screening in persons at high risk for infection, and a one-time screening for adults born between 1945 and 1965
  - HIV screening and counseling for adolescents and adults ages 15 to 65 years, and to younger adolescents and older adults who are at increased risk
  - HIV Screening for pregnant women including those who present in labor who are untested and whose HIV status is unknown
  - Hypothyroidism screening for congenital hypothyroidism in newborns

- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, including coverage for children from birth through the date of the child's sixth birthday for immunizations against diphtheria; haemophilus influenza type b; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; rotavirus; and varicella; and any other immunization that is required for the child by law.
- Intimate partner violence screening for women of reproductive age, and ongoing support for women who screen positive
- Lung cancer screening with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery
- Obesity Screening and Counseling for adults. The USPSTF recommends that clinicians offer or refer adults with a body mass index of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions
- Obesity screening for children and adolescents. The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status
- Osteoporosis screening with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than age 65 years at increased risk for osteoporosis, as determined by a formal clinical risk assessment tool
- Osteoporosis screening with bone measurement testing to prevent osteoporotic fractures in women age 65 years and older
- Perinatal depression counseling and interventions for pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions
- Phenylketonuria screening in newborns
- Preeclampsia prevention with the use of low-dose aspirin as a preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia
- Preeclampsia screening in pregnant women with blood pressure measurements throughout pregnancy
- Preexposure prophylaxis (PrEP) with effective antiretroviral therapy for persons who are at high risk of HIV acquisition.
- Prostate Screening – A physical examination for the detection of prostate cancer; one prostate specific antigen (PSA) test or an equivalent serological test will be covered per calendar year for men 50 years of age and asymptomatic, or for men 40 years of age with a family history of prostate cancer or another prostate cancer risk factor. More PSA tests will be covered if recommended by a Physician.
- Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care, and Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks gestation unless the biological father is known to be Rh(D)-negative
- Sexually transmitted infections counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections
- Skin cancer behavioral counseling for young adults, adolescents, children, and parents of young children about minimizing their exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer
- Statin preventive medication for adults ages 40-75 with no history of cardiovascular disease for the prevention of cardiovascular disease events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years
- Syphilis screening for non-pregnant persons who are at increased risk for infection



- Syphilis screening for pregnant women. The USPSTF recommends early screening for syphilis infection in all pregnant women
- Tobacco use counseling and interventions for nonpregnant adults. The USPSTF recommends that clinicians ask all adults about tobacco, advise them to stop using tobacco, and provide behavioral interventions and FDA-approved pharmacotherapy for cessations to adults who use tobacco
- Tobacco use counseling and interventions for pregnant women. The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco
- Tobacco use interventions for children and adolescents. The USPSTF recommends that clinicians provide interventions, including brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents
- Tuberculosis screening for latent tuberculosis infection in populations at increased risk
- Unhealthy alcohol use screening for adults. The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use
- Visual screening for all children at least once between the ages of 3 and 5 years to detect the presence of amblyopia or its risk factors.
- Well Baby Visits and Care after initial newborn examination and discharge from the hospital
- Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care
- Any other preventive services included in the A or B recommendations of the task force for the particular preventive health care service or as required by state or federal law. For a complete list of Preventive Care services, please visit the USPSTF website: <http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations>

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

**Note:** If a Covered Person receives the same preventive screening more than once in a 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 Percentage Copayment.

### **Prosthetic and Orthotic Devices**

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

- Prosthetics will be covered in accordance with recommended guidelines and criteria
- Bionic, myoelectric, microprocessor-controlled, and computerized Prosthetics are covered in accordance with Medicare guidelines and criteria
- Artificial face, eyes, ears, and noses
- Speech aid prosthetics and tracheo-esophageal voice prosthetics
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm
- Services related to the fitting and use of the devices above

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

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

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

Medically Necessary foot orthotics that are consistent with the Medicare Benefit Policy Manual are covered subject to the same Deductibles, Percentage Copayment Amounts and Copayment Amounts as for services and supplies generally. There is no Calendar Year maximum, though benefits for foot orthotics require Preauthorization if greater than \$500 a year. This is in addition to, and does not affect the coverage for, Podiatric appliances as shown in the "Diabetes" section.

### **Implanted Medical Devices**

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

### **Radiation Services - Outpatient**

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

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

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

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

### **Reconstructive Procedures**

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

Covered Health Services under this section include reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all states of mastectomy

Covered Health Services under this section includes coverage reconstructive surgery for craniofacial abnormalities for a child who is younger than 18 years of age. Reconstructive surgery for craniofacial abnormalities means surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

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.

### **Scopic Procedures – Outpatient Diagnostic and Therapeutic**

Covered Health Services under this section include diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility. Diagnostic scopic procedures are those for visualization, biopsy, and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

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

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

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

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

Coverage is limited to one hundred (100) days per calendar year.

### **Sleep Studies**

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

### **Speech and Hearing Services**

Covered Health Services include services by a Physician or Other Professional Provider to restore loss of or correct an impaired speech or hearing function. Benefits for speech and hearing services, including but not limited to, speech therapy, cochlear implants and hearing aids require Preauthorization.

We cover Medically Necessary hearing aid or cochlear implant and related services and supplies for Covered Persons. Coverage includes fitting and dispensing services, treatment for habilitation and rehabilitation, and for cochlear implant, an external speech processor and controller with necessary component and replacement every three (3) years.

### **Surgery – Outpatient**

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

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

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

### **Telemedicine, Teledentistry, and Telehealth**

We cover Medically Necessary Covered Services offered through Telemedicine, Teledentistry, or Telehealth by an In-Network Provider subject to the terms and conditions of Our contracts with In-Network Providers. We cover Medically Necessary Covered Services delivered by In Network Providers, through Telemedicine, Teledentistry, or Telehealth, on the same basis and to the same extent that We provide coverage for the Medically Necessary Covered Services in an in-person

setting. We will not deny coverage for Health Care Services on the sole basis that the Health Care Service was provided through Telemedicine, Teledentistry, or Telehealth and not through an in-person consultation. You will not be subject to any greater Deductible, Co-Payment, or Percentage Copayment amount than would be applicable if the same Health Care Service was provided through an in-person consultation. We do not cover visits offered through (1) an audio-only telephone consultation; (2) a text-only e-mail message; or (3) a facsimile transmission.

### **Transplant Services – Organ and Tissue**

Covered Health Services and supplies provided to a Covered Person by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:

- The transplant procedure is not Experimental/Investigational in nature;
- Donated human organs or tissue or an FDA-approved artificial device are used;
- The recipient is a Covered Person under the Plan;
- The transplant procedure is preauthorized as required under the Plan;
- The Covered Person meets all of the criteria established by Us in pertinent written medical policies; and
- The Covered Person meets all of the protocols established by the Hospital in which the transplant is performed.

Covered Health Services and supplies related to an organ or tissue transplant include, but are not limited to x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

Covered Health Services are available and will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above.

Coverage is available for:

- A recipient who is a Covered Person under this Plan; and
- A donor who is a Covered Person under this Plan; or
- A donor who is not a Covered Person under this Plan.

Covered Health Services and supplies include:

- Evaluation of organs or tissues including, but not limited to, the determination of tissue matches of the donor; and
- Removal of organs or tissues from living or deceased donors; and
- Transportation and short-term storage of donated organs and tissues; and
- Procurement of organs or tissues from a living or deceased donor.

Covered services and supplies do not include services and supplies provided for the:

- Living expenses of the recipient or a live donor;
- Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
- Purchase of the organ or tissue; or
- Organs or tissue (xenograft) obtained from another species.

Pre-authorization is required for any organ or tissue transplant. Review Section 5 – How to Access Your Services and Obtain Approval of Benefits section in this EOC for more specific information about Pre-authorization.

- Such specific Pre-authorization is required even if the patient is already a patient in a Hospital under another Pre-authorization.
- At the time of Pre-authorization, We will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if We determine that an extension is Medically Necessary.

No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which We consider to be Experimental/Investigational.

**Travel Expenses**

Covered Services under this benefit include reimbursement for travel expenses primarily related to Transplantation Services, including meals and lodging when it is necessary for a Covered Person to receive care from a designated Center of Excellence facility that is located more than 100 miles from the Covered Person's home.

Travel expenses are also reimbursable if We direct You for treatment at a facility more than 100 miles from Your home because treatment is not available In-Network, within Our Service Area.

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

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

**Urgent Care Center Services**

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

## **Section 7 – Limitations/Exclusions (What is Not Covered)**

### **HOW WE USE HEADINGS IN THIS SECTION**

To help You find specific exclusions more easily, We use headings (for example A. Alternative Treatments below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit, or expand an exclusion. All exclusions in this section apply to You.

### **BENEFIT LIMITATIONS**

When Benefits are limited within any of the Covered Health Service categories described in Benefits/Coverages (What is Covered) section of this EOC, those limits are stated in the corresponding category in the Schedule of Benefits (Who Pays What) section of this EOC. 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 EOC under the Benefit Limits heading. Please review all limits carefully as We will not pay Benefits for any of the services, treatments, items, or supplies that exceed these Benefit limits.

### **BENEFIT EXCLUSIONS**

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

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

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

**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**

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

- CT scans, MRIs, x-rays and laboratory services which are not within his or her scope of practice, as defined by state law.
- Charges for care not provided in an office setting.
- Manipulation under anesthesia.
- Maintenance or preventive treatment consisting of routine, long term or Non-Medically

appropriate care provided to prevent reoccurrences or to maintain the patient's current status.

- Vitamin or supplement therapy.
- Supplies ordered by a chiropractor.
- Infusion therapy or chelation therapy.

This exclusion shall not apply to any Medically Necessary Covered Health Service performed by a chiropractor if the service is within the scope of the chiropractor's license.

### **Custodial or Domiciliary Care**

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

Assistance with activities of daily living including 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 not covered.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which benefits are available under the EOC, 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. This exclusion does not apply to accident-related dental services or for services related to the treatment of cleft lip and cleft palate.

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

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.

### **Devices, Appliances**

Health care services excluded under this provision include the following devices or appliances even when prescribed by a Physician.

- Devices used specifically as safety items or to affect performance in sports-related activities
- Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics (except for diabetic shoes), cranial banding and some types of braces, including over-the-counter orthotic braces
- Enuresis alarm
- Blood Pressure cuff/monitor
- Cold-circulating devices
- Cold packs
- TENS units
- Home coagulation testing equipment
- Non-Wearable external defibrillator
- Trusses
- Ultrasonic nebulizers
- Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics
- Oral appliances to treat sleep apnea or snoring
- Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes

### **Directed Blood Donations**

Directed Blood Donations are excluded from coverage.

### **Employer or Governmental Responsibility**

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

### **Experimental, Investigational, or Unproven Services**

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

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

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

Denials for services deemed Experimental, Investigational, or Unproven are adverse determinations subject to the utilization review process, including review by an independent review organization.

### **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 rendered in relation to diabetes for which coverage is provided as described under the Benefits/Coverage (What is Covered) section of this EOC.

### **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.

### **Infertility & Reproductive Services**

Health care services excluded are:

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

### **Medical Supplies and Equipment**

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

- 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

### **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 Autism Spectrum Disorder, Early Childhood Intervention Services, and Habilitative Services.

### **Nutritional Counseling**

Health care services excluded under this provision include the following:

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

### **Other Services**

Health care services excluded under this provision include the following:

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

### **Pediatric Dental Care – Limitations**

- Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called “Optional Services.” Optional Services also include the use of specialized techniques instead of standard procedures. If a Covered Person receives Optional Services, an alternate Benefit will be allowed, which means the We will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Covered Person will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.
- Claims shall be processed in accordance with Our standard processing policies. The processing policies may be revised from time to time; therefore, We shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.
- If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under the dental Benefits. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.
- Exam and cleaning limitations
  - We will pay for oral examinations (except after hours exams and exams for observation) and routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) no more than once every six (6) months. Periodontal maintenance is limited to four (4) times in a 12-month period. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings, including scaling in presence of generalized moderate or severe

gingival inflammation (or any combination thereof) not to exceed four (4) procedures in a 12-month period.

- A full mouth debridement is allowed once in a lifetime, when the Covered Person has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three years, and counts toward the cleaning frequency in the year provided.
- Note that periodontal maintenance, Procedure Codes that include periodontal maintenance, and full mouth debridement are covered as a Basic Benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.
- Caries risk assessments are allowed once in 36 months.
- X-ray limitations:
  - If a panoramic film is taken in conjunction with an intraoral complete series, We consider the panoramic film to be included in the complete series.
  - A complete intraoral series and panoramic film are each limited to once every 60 months.
  - Bitewing x-rays are limited to once every six (6) months. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
- The fee for pulp vitality tests 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 distal shoe space maintainer - fixed - unilateral is limited to children 8 and younger and is limited to once per quadrant per lifetime. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe. The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.
- Sealants are limited as follows:
  - once in 36 months to permanent molars if they are without caries (decay) or restorations on the occlusal surface.
  - repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement.
- Preventive resin restorations in a moderate to high risk caries risk patient - permanent tooth are limited to once per tooth in 36 months.
- Specialist Consultations count toward the oral exam frequency.
- We will not cover replacement of an amalgam or resin-based composite restorations (fillings) within 24 months of treatment if the service is provided by the same Provider/Provider office. Prefabricated crowns are limited to once per Covered Person per tooth in any 60-month period. Replacement restorations within 24 months are included in the fee for the original restoration.
- Protective restorations (sedative fillings) are allowed when definitive treatment is not performed on the same date of service. The fee for protective restorations is included in the fee for any definitive treatment performed on the same date.
- Prefabricated stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16. Replacement restorations within 24 months are included in the fee for the original restoration.
- Therapeutic pulpotomy is limited to baby (deciduous) teeth only; an allowance for an emergency palliative treatment is made when performed on permanent teeth.
- Pulpal therapy (resorbable filling) is limited to once in a lifetime and to primary incisor teeth for Covered Persons up to age 6 and for primary molars and cuspids up to age 11. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.
- Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation.
- Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

- Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.
- Palliative treatment is covered per visit, not per tooth, and the fee for palliative treatment provided in conjunction with any procedures other than x-rays or select Diagnostic procedures is considered included in the fee for the definitive treatment.
- Periodontal limitations:
  - Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service.
  - Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same dentist/dental office.
  - Periodontal services, including graft procedures are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
  - Bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
  - Periodontal surgery is subject to a 30-day wait following periodontal scaling and root planing in the same quadrant.
  - Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
  - When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a basic benefit and are limited to once in a 24-month period.
- Collection and application of autologous blood concentrate product are limited to once every 36 months.
- Crowns and Inlays/Onlays are covered not more often than once in any 60-month period except when We determine the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues. Services will only be allowed on teeth that are developmentally mature.
- Core buildup, including any pins, is covered not more than once in any 60-month period.
- Prefabricated post and core, in addition to crown is covered once per tooth every 60-month period.
- Resin infiltration of incipient smooth surface lesions is covered once in any 36-month period.
- When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.
- Prosthodontic appliances, implants and/or implant supported prosthetics (except for implant/abutment supported removable dentures) that were provided under any Dental Plan program will be replaced only after 60 months have passed, except when We determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under the pediatric dental plan will be made if We determine it is unsatisfactory and cannot be made satisfactory. Services will only be allowed on teeth that are developmentally mature. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Payment for implant removal is limited to one (1) for each implant within a 60-month period.
- Debridement and/or osseous contouring of a peri-implant defect, or defects surrounding a single implant, and includes surface cleaning of the exposed implant surface, including flap entry and closure is allowed once every 60-month period.
- An implant is a covered procedure of the plan only if determined to be a dental necessity. If an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of

- treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.
- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Covered Service.
  - Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement.
  - The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Covered Person was covered under this Pediatric Dental Plan.
  - This Plan limits payment for dentures to a standard partial or complete denture (Covered Person Percentage Copayments applies). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six (6) months after placement.
    - Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.
    - Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, relining is limited to one (1) per arch in a 36-month period.
    - Tissue conditioning is not allowed as a separate Covered Service when performed on the same day as a denture reline or rebase service.
  - Occlusal guards are covered by report for Covered Persons age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJ). Occlusal guards are limited to one (1) per 12 consecutive month period. We will not cover the repair or replacement of any appliances for Night Guard/Occlusal Guard. Adjustment of an occlusal guard is allowed once in 12-months following six months from initial placement.
  - Limitations on Orthodontic Services
    - Services are limited to medically necessary orthodontics when provided by a Provider and when necessary and customary under generally accepted dental practice standards. Orthodontic treatment is a benefit of the Pediatric Dental Plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained.
    - Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.
    - The automatic qualifying conditions are:
      - Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request.
      - A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate.
      - A crossbite of individual anterior teeth causing destruction of soft tissue.
      - Severe traumatic deviation.
    - The following documentation must be submitted with the request for prior authorization of services by the Provider:
      - ADA 2006 or newer claim form with service code(s) requested
      - Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent
      - Cephalometric radiographic image or panoramic radiographic image
      - HLD score sheet completed and signed by the Orthodontist; and
      - Treatment plan
    - The allowances for comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Covered Person is permitted.
    - Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.

- Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Covered Person s under the age of 19 and shall be prior authorized.
- Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Covered Person is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
- All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
- When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, We will make an allowance for the cost of a standard orthodontic treatment. The Covered Person is responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist's charge for the specialized orthodontic appliance or procedure.
- Repair and replacement of an orthodontic appliance inserted under this plan that has been damaged, lost, stolen, or misplaced is not a covered service.

### **Pediatric Dental Care – Exclusions**

We will not pay Benefits for the following:

- Services that are not Essential Health Benefits.
- Treatment of injuries or illness covered by workers' compensation or employers' liability laws.
- Services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- Cosmetic surgery or procedures for purely cosmetic reasons.
- Maxillofacial prosthetics.
- Provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.
- Treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to equilibration, periodontal splinting, or complete occlusal adjustments.
- Any Single Procedure provided prior to the date the Covered Person became eligible for services under this plan.
- Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/ investigational procedures.
- Charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
- Extra-oral grafts (grafting of tissues from outside the mouth to oral tissues).
- Laboratory processed crowns for teeth that are not developmentally mature.
- Endodontic endosseous implants.
- Indirectly fabricated resin-based Inlays/Onlays.
- charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- Treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer

screening, tobacco counseling or broken appointments are not separately payable procedures.

- Dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits, will be the responsibility of the Covered Person and not a covered Benefit.
- Deductibles and/or any service not covered under the Pediatric Dental Plan.
- Services covered under the Pediatric Dental Plan but that exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- Initial placement of any prosthodontic appliance or implant, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Covered Person is covered under this Pediatric Dental Plan. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.
- Services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.
- Services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided a prior authorization is obtained.
- Missed and/or cancelled appointments.
- Actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- Fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- Dental case management motivational interviewing and patient education to improve oral health literacy.
- Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- Extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.

#### **Personal Care, Comfort, or Convenience**

Items excluded under this provision include the following:

- Beauty/barber services
- Guest service
- Telephone
- Television
- Supplies, equipment, and similar incidental services and supplies for personal comfort.

Examples include:

- Air conditioners, air purifiers and filters, dehumidifiers
- Batteries and battery chargers
- Car seats
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners
- Electric scooters
- Exercise equipment
- Home modifications such as elevators, handrails, and ramps
- Hot tubs
- Humidifiers
- Jacuzzis/whirlpools/saunas
- Mattresses
- Medical alert systems
- Motorized beds

- Music devices
- Personal computers
- Pillows
- Power-operated vehicles
- Radios
- Safety equipment
- Speech generating devices
- Stair lifts and stair glides
- Strollers
- Treadmills
- Vehicle modifications such as van lifts
- Video players

### **Physical Appearance**

Health care services excluded under this provision include the following:

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

### **Physician Assisted Suicide**

Services provided by a Physician or medical professional to assist a Covered Person in ending his or her life are excluded from coverage under this plan.

### **Prescription Drug Exclusions**

Health care services excluded under this provision include the following:

- Prescription Drug Products obtained through a Non-Network Pharmacy.
- Non-Prescription Medications (medications that do not require a prescription), unless specifically included as covered elsewhere in this document, or mandated by Law.
- Medications for which the condition or services are excluded under your Schedule of Benefits or the EOC.
- Medications not approved by the FDA.
- Early prescription refills to replace a lost, stolen, or destroyed prescription or prescription supplies, or exceeding the Day's Supply Limit, Quantity or Supply Limits.
- Medications prescribed solely for cosmetic purposes.



- Human Growth Hormone prescribed to adults for any reason.
- Medications available as bulk powder only.
- Medications which are labeled or deemed Investigational or Experimental, including regimens that are unproven.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Prescription Drug Products furnished by local, state, or federal government. Any Prescription Drug Product to the extent payment or Benefits is provided or available from the local, state, or federal government (for example, Medicare) whether or not payment or Benefits are received, except as otherwise provided by law.
- Prescription Drug Products for any condition, Injury, Sickness, or Mental Illness arising out of, or in the course of, employment for which Benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such Benefits is made or payment or Benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Durable Medical Equipment.
- Prescribed and non-prescribed outpatient supplies, other than diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins except as described under the Preventive and Wellness Services of the Benefits/Coverage (What is Covered) section of this EOC.
- Medication prescribed for the treatment of hair loss
- Off-label use of medications unless required by Law, then allowed in accordance with Law.
- Biological sera, blood, blood products or plasma.
- Oxygen, Medical Devices or Equipment, unless specifically listed as covered.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms that We determine do not meet the definition of a Covered Health Service.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury
- Medications used to treat Erectile Dysfunction.
- Topical medications for the treatment of onychomycosis of the toenails.
- Allergy serum.
- Medications for the treatment of Infertility.
- Prescription drugs with a non-prescription equivalent except as described under the Preventive and Wellness Services of the Benefits/Coverage (What is Covered) section of this EOC.
- Unit-dose or re-packaged medications, or costs related to re-packaging of available covered medications.
- Marijuana, including but not limited to medical marijuana for any reason.

### **Prescription Drugs Limitations**

Health care services limited under this provision include the following:

- 30-day supply of covered medications per prescription is allowed, other quantity limits may be applied to claims.
- All medications are subject to our utilization review process and quantity limits. New prescriptions to treat certain chronic conditions are limited to a 30-day supply. In addition, certain medications may be subject to any quantity limits applied as part of our trial program. A 90-day supply will be covered and dispensed only at pharmacies that participate in our extended day supply program. No more than a 30-day supply of Specialty Medications will be covered and dispensed at a time.
- If a Covered Person requests a brand medication when there is a generic equivalent, the brand medication will be covered up to the charge that would apply to the generic medication, minus any required copayment. If a physician requests that a brand medication be dispensed as written, the medication will be paid at the non-formulary (Tier 4) benefit.
- The Covered Person copayment for a medication will not exceed the cost of the medication.
- If a Covered Person copayment is required, you must pay one Covered Person copayment for each 30-day supply, or portion thereof, except for Mail Order Medications.

**Private Duty Nursing**

Services for nursing care that are provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting are excluded from coverage under this plan. This exclusion shall not apply to inpatient private duty nursing services when Medically Necessary.

**Procedures and Treatments**

Health care services excluded under this provision include the following:

- Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.
- Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
- Psychosurgery.
- Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- Speech therapy except as required for habilitative treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorders.
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or Medically Necessary treatment of Temporomandibular Joint Disorder, dislocation, tumors, orthognathic surgery, jaw alignment, or cancer.
- Remote surgical neuromonitoring.

**Providers**

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

This exclusion does not apply to mammography.

**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 EOC Coverage Period**

Health services received prior to your EOC 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 *EOC* ended.

**Services Rendered by a Non-Network Provider**

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

Exceptions to this exclusion are:

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

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

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

### **Services that are not Medically Necessary**

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

### **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 EOC;
- 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 EOC.)
- 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 EOC.

### **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 EOC
- Rest cures
- Services of personal care attendants
- Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work)

### **Vision Services**

Health care services excluded under this provision include the following:

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

### **All Other Exclusions**

Items excluded under this provision include the following:

- Administrative services.
- Aids or devices that assist with non-verbal communications.
- Ambulance services that are not Medically Necessary.
- Autopsy, except as may be reasonably required by Us at Our own expense.
- Charges for services provided by a stand-by Physician.

- Charges in excess of the Allowed Amount or in excess of any specified limitation.
- Charges unsupported by medical records.
- Claims received by us after 12 months from the date service was rendered, except in the event of legal incapacity or as required by law.
- Continuous glucose monitoring for patients who are not Type I diabetics
- Court-ordered testing, except for mental health or substance abuse testing or treatment as required by state law.
- Free care.
- Gym fees or memberships.
- Health services received in consequence of being intoxicated or under the influence of any narcotic, unless administered on the advice of a physician.
- Health services and supplies that do not meet the definition of a Covered Health Service - see the Definitions section.
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- Health services 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 EOC.
- 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 EOC 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 EOC.
  - 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 EOC.
- Services received because of participation in an insurrection, rebellion or riot.
- Services received as a result of a commission of, or an attempt to commit a felony (whether or not charged) or as a result of being engaged in an illegal act or occupation.
- Virtual colonoscopy including CT colonography and capsule endoscopy and colonography
- Virtual coronary angiography and coronary calcium scans.
- Voluntary or elective medical or surgical abortions and any related services, drugs or supplies are excluded. This exclusion shall not apply to any abortion performed due to a medical emergency. For purposes of this exception, "medical emergency" means a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places a women in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.

## **Section 8 – Member Payment Responsibility**

### **YOUR RESPONSIBILITIES**

#### **Show Your ID Card**

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

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

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

#### **Pay Your Share**

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

#### **Pay the Cost of Excluded Services**

You must pay for services that are not covered. These are called Excluded Services. Please review the Limitations/Exclusions (What is Not Covered) section of this EOC so you know what is not covered.

### **OUR RESPONSIBILITIES**

#### **Pay for Our Portion of the Cost of Covered Health Services**

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

#### **Pay Network Providers**

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

#### **Offer Health Education Services to You**

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

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

### **IF YOU RECEIVE COVERED HEALTH SERVICES FROM A NETWORK PROVIDER**

We pay Providers for Your Covered Health Services. You are responsible for meeting Your Annual Deductible and for paying any required Copayments and Percentage Copayment 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 Covered Person to receive payment for services directly from the Us, We will honor the agreement and pay the Provider.

### **REQUIRED CLAIM INFORMATION**

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

- Subscriber's name and address.
- Patient's name and date of birth.
- ID number stated on Your ID card.
- Name, address and 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**

Written notice of claim must be furnished to Us within twenty (20) days after the occurrence of any loss covered by the EOC, or as soon thereafter as is reasonably possible. Electronic submission of the notice of claim is acceptable as submission on paper. Failure to furnish such notice of claim within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time. In no event, except in the absence of legal capacity of the claimant, shall proof be furnished later than one (1) year from the date of loss.

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

### **PROOF OF LOSS**

Written proof of loss must be furnished to the insurer within 90 days after the termination of the period for which the insurer is liable and, in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

### **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 Subscriber 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 EOC. Foreign claims must be translated in U.S. currency prior to being submitted to the Plan for payment.

You may find the required claim forms on our website at [www.brighthealthcare.com](http://www.brighthealthcare.com) or by calling Customer Service at the number listed on Your ID Card.

## **PAYMENT OF CLAIMS UPON DEATH**

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

## **FINALIZATION OF CLAIMS**

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

## **TIMELY FILING**

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

Bright HealthCare Insurance Company of Texas  
P.O. Box 1519  
Portland, ME 04104

## **TIME OF PAYMENT OF CLAIMS**

Claims payable under this EOC for any loss, other than loss for which this EOC 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 EOC 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 EOC 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 EOC.
- 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.

### **USE AND DISCLOSURE OF CERTAIN TYPES OF MEDICAL INFORMATION**

For certain types of PHI, state laws may provide greater protection for your privacy. For example, use and/or disclosure of PHI including, but not limited to HIV/AIDS, genetic information, mental health information, alcohol and substance abuse information may need to be specifically authorized by you or be required by law. In such instances, we will follow the provisions of that state law. We are prohibited from using or disclosing your genetic information for underwriting purposes.

### **OUR RELATIONSHIP WITH PROVIDERS**

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

### **YOUR RELATIONSHIP WITH PROVIDERS**

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

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

### **INCENTIVES TO PROVIDERS**

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

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

### **INCENTIVES TO YOU**

We may offer You incentives to encourage You to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is Yours.



alone but We recommend that You discuss participating in such programs with Your Physician. Contact Us if You have any questions.

### **REBATES AND OTHER PAYMENTS**

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

### **INSPECTION OF EOC**

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

### **INTERPRETATION OF BENEFITS**

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

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

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

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

### **EVALUATION OF NEW TECHNOLOGY**

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

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

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

### **ADMINISTRATIVE SERVICES**

We may, in Our sole discretion, arrange for various persons or entities to provide administrative services in regard to this EOC, 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 EOC, 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 EOC 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 EOC, 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 EOC, We and Our related entities may use and transfer the information gathered under this EOC in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to Our Notice of Privacy Practices.

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

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

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

## **CHANGE OF BENEFICIARY**

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

## **EXTENSION OF BENEFITS**

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

## **EXAMINATION AND AUTOPSY**

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

## **INTEGRATION OF MEDICARE BENEFITS**

Benefits under this Plan will pay secondary to Medicare only. We will not coordinate benefits with other plans. We will not provide benefits that duplicate any benefits You would be entitled to receive under Medicare.

If You have Medicare, Your Medicare coverage will not affect the Covered Services covered under this EOC, except as follows:

- Your Medicare coverage will be applied first (primary) to any services covered by both Medicare and this EOC.

- If You receive a service that is covered both by Medicare and this EOC, 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 EOC. All benefits payable under this EOC are subject to the applicable deductible, copayment and/or Percentage Copayment for the Covered Health Service as outlined in the Schedule of Benefits.

### **ELIGIBILITY FOR MEDICARE**

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

### **ELIGIBILITY FOR MEDICAID**

If a Participant under the Plan is also a Medicaid recipient, any benefits for services or supplies under the Plan will not be excluded solely because benefits are paid or payable for such services or supplies under Medicaid. Any benefits available under the Plan will be payable to the Texas Department of Human Services to the extent required by the Texas Insurance Code.

### **WORKERS' COMPENSATION**

Benefits provided under this EOC 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 Texas Department of Labor, if necessary.

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

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

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

- If You have an appeal pending in front of the Texas Department of Labor. We may pay claims for certain services if You sign an agreement to repay the Plan for 100 percent of services paid by Us when the appeal is decided in Your favor.
- If You qualify under Texas 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.
- We may, if You do not file a claim, take necessary and appropriate action to preserve Our rights under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay You part of any recovery We might obtain.
- 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:

- All or some of the payment We made that exceeded the Benefits under this EOC.
- All or some of the payment that was made in error.

The refund equals the amount We paid in excess of the amount that We should have paid under this EOC. 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 3 months for individuals receiving federal insurance subsidies will be allowed for the payment of all outstanding premiums. If the full balance of outstanding premium is not paid within Your grace period, coverage will end on the last day of the first calendar month of the grace

period. For non-subsidized Covered Persons, a 31-day grace period will be allowed for the payment of all outstanding premiums. If the full balance of outstanding premium is not paid within Your grace period, coverage will end on the last day for which You have paid Your premium. We will provide You notice of Your nonpayment before cancelling Your EOC. We will not pay for any services received on or after the date Your coverage ends.

### **UNPAID PREMIUMS**

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

### **LIMITATION OF ACTION**

No action at law or in equity shall be brought to recover on this EOC prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this EOC. 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 the option to agree to the use of arbitration in lieu of having any such dispute decided in a court of law before a jury.

### **CONFORMITY WITH STATE STATUTES**

If this EOC contains any provision or part of a provision not in conformity with Texas Insurance Code Chapter 1271 or other applicable laws, the remaining provisions and parts of provisions that can be given effect without the invalid provision or part of a provision are not rendered invalid but must be construed and applied as if they were in full compliance with Texas Insurance Code Chapter 1271 and other applicable laws.

### **FRAUDULENT INSURANCE ACTS NOTICE**

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

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

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

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

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

### **TIME LIMIT ON CERTAIN DEFENSES**

After two years from the effective date of this EOC, in the absence of fraud, no misstatements made by the Subscriber in the enrollment application may be used by Us to cancel this EOC 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 EOC has been in force for a period of two (2) years, We may not contest any statements contained in the Application.

**INCONTESTABILITY**

All statements made by the Subscriber on the enrollment application are considered representations and not warranties. The statements are considered truthful and made to the best of a Subscriber's knowledge and belief. A statement may not be used in a contest to void, cancel, or nonrenew a Covered Person's coverage or reduce benefits unless:

- It is in a written enrollment application signed by the Subscriber; and
- A signed copy of the enrollment application is or has been furnished to the Subscriber or the Subscriber's personal representative.

A statement made by the Subscriber on the enrollment application may only be used in a contest to void, cancel, or nonrenew a Covered Person's coverage or reduce benefits because of fraud or intentional misrepresentation of material fact made on the enrollment 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.

**PRE-EXISTING CONDITIONS**

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

**OTHER INFORMATION YOU SHOULD HAVE**

We have the right to change, interpret, modify, withdraw, add Benefits, or terminate this EOC, without Your approval, as permitted by law. Benefits provided under this plan will comply with coverage standards as required by law. We must notify You of material changes to this EOC at least 60 days in advance of the change.

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

We are delivering this EOC in the State of Texas. To the extent that state law applies, the laws of the State of Texas are the laws that govern this EOC.

## **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.

This EOC is renewable at the option of the Covered Person, except for the conditions stated below. We will terminate your EOC at the end of the month in which the following events occur, unless stated otherwise:

- The required premium was due to Us, including any Grace Period, and not received by Us, including any outstanding premium balance. Termination will be effective on the last day for which the premium was paid. For purposes of this section, “Grace Period” means three months for Covered Persons receiving federal insurance subsidies and 31 days for non-subsidized Covered Persons.
- Fraud or intentional misrepresentation of material fact, in which case, termination will be effective not less than 15 days after written notice is sent to You.
- Fraud in the use of services or facilities, in which case, termination will be effective not less than 15 days after written notice is sent to You.
- The Covered Person no longer resides, lives, or works within the Service Area as determined by Us, but only if coverage is terminated uniformly without regard to any health status-related factor of the Covered Person, in which case, termination will be effective not less than 30 days after written notice is sent to You. This provision shall not apply to a Child who is the subject of a medical support order.
- We cease to offer a particular type of individual coverage or cease to do business in the individual basic healthcare market as allowed by federal or State law.

You request termination of the EOC in writing.

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.

### **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 EOC. This is provided, however, that if We require an application for reinstatement and issue a conditional receipt for the premium paid, the EOC will be reinstated upon approval of application by Us or, lacking such approval, upon the forty-fifth day following the date of the conditional receipt unless We have previously notified You in writing of Our disapproval of Your application. The reinstated EOC shall cover only loss resulting from Accidental Injuries sustained after the date of reinstatement and loss due to Illnesses. In all other respects You and Us shall have the same rights as existed under the EOC immediately before the due date of the defaulted premium, subject to any endorsements attached to the reinstated EOC. Any premiums accepted in connection with a reinstatement will be applied to a period for which You have not previously paid premium, but not to exceed sixty days prior to the date of reinstatement.

In the event of the insured's death, the spouse of the insured, if covered under this EOC, shall become the insured.

If a Covered Person loses coverage due to a change in marital status, that covered person shall be issued a EOC which was in effect prior to the change in marital status, and which will be issued without evidence of insurability and which will have the same effective date as the previous EOC.

## 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 Your 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/cfas-data.html>.

### WHAT TO DO IF YOU HAVE A QUESTION

Contact *Customer Service* at 1-844-926-4524. *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 1-844-926-4524. *Customer Service* representatives are available to take Your call.

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

Bright Health Group  
PO Box 1519  
Portland, ME 04104

Or, by faxing the request to: 1-877-471-0295

If the *Customer Service* representative cannot resolve the issue to Your satisfaction over the phone, he/she can help You prepare and submit a written complaint. We will notify You of Our decision regarding Your complaint within 30 days of receiving it. We may require that You sign a written acknowledgement of Your oral complaint, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the complaint.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited complaints, depending on the nature of Your inquiry.

We will investigate your Complaint and notify you of its resolution within 30 days of receiving your request.

If a Complaint involves an emergency or denial of continued hospitalization, We will investigate and resolve the Complaint within one business day of receiving the Complaint.

### WHAT IS AN ADVERSE DETERMINATION?

**ADVERSE DETERMINATION MEANS A DETERMINATION BY US THAT HEALTH CARE SERVICES PROVIDED OR PROPOSED TO BE PROVIDED TO A COVERED PERSON ARE NOT MEDICALLY NECESSARY OR ARE EXPERIMENTAL OR INVESTIGATIONAL. THE TERM DOES NOT INCLUDE A DENIAL OF HEALTH CARE SERVICES DUE TO THE FAILURE TO REQUEST PROSPECTIVE OR CONCURRENT UTILIZATION REVIEW. IN THE**



**CASE OF A PRESCRIPTION DRUG, IT IS AN ADVERSE DETERMINATION IF WE REFUSE TO PROVIDE BENEFITS IF THE DRUG IS NOT INCLUDED IN THE OUR FORMULARY AND YOUR PHYSICIAN HAS DETERMINED THAT THE DRUG IS MEDICALLY NECESSARY.**

### **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. Adverse determinations involving life threatening conditions, prescription drugs, or intravenous infusions are entitled to immediate appeal to an independent external review entity through the independent external review process. See the "Independent External Review" and "Expedited Independent External Review" sections, below.

### **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:

- Description of the Adverse Determination
- Reason You disagree with the Adverse Determination; and
- Any documentation (including medical records) or other written information to support Your position
- 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.

### **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.

### **Prescription Drugs**

We shall provide notice of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions for which the patient is receiving health benefits under the health insurance EOC not later than the 30<sup>th</sup> day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.

### **STANDARD APPEAL**

If Your Appeal relates to a Preauthorization request, We will decide the Appeal and provide written notification of our decision within 30 calendar days of receipt of the Appeal request.

### **RETROSPECTIVE APPEAL**

If your appeal relates to retrospective review of a claim, We will make a decision and provide written notification of Our decision within 30 calendar days of receipt of the appeal request.

## **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.

The expedited appeal process also applies to appeals of adverse determinations related to emergency care, life-threatening conditions, prescription drugs, requests for continued hospitalization or intravenous infusions.

An expedited appeal request does not need to be submitted in writing. An expedited appeal may be requested by calling us directly at the Customer Service number listed in Section 2 of this EOC 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.

Expedited appeal requests will be decided based on the medical immediacy of Your condition, procedure, or treatment, but in no event later than one working day from the date of Our receipt of the information necessary to complete the appeal.

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

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

## **INDEPENDENT EXTERNAL REVIEW**

### **Independent External Review Process**

After You have gone through the internal appeal, You may request an independent external review. We are responsible for paying the cost of the independent external review; there is no cost to You.

To begin the process, You, Your Physician or Your designated representative must submit a written request for an independent external review no later than four (4) months after receiving notice of the appeal determination from the internal appeal. You may also submit Your request for an independent external review at the same time You request an expedited internal review.

Independent external review requests must be submitted to Us in writing. You must also include a signed consent form, authorizing Us to disclose protected health information, including medical records, pertinent to the external review. You may include with Your request new information, if it is significantly different from the information provided or considered during the internal review process.

We participate in the federal external review process, which is administered by the Department of Health and Human Services and currently managed by MAXIMUS (the "IRO"). We will forward a copy of Your request to the IRO. You may submit additional information for consideration directly to the IRO, and the IRO will forward Us a copy of any information You send them. We will send the IRO the documents and information We considered in making Our Adverse Determination. the IRO

will provide You with an index of all materials that We submit. Upon request, We will provide You with all relevant information we supply to the IRO that is not confidential or privileged under state or federal law concerning the case under review. The IRO will notify You and Us if additional information is required.

We have the option of reversing Our Adverse Determination based on a consideration of any new information You may submit. If we reverse our Adverse Determination, We will notify You, the Department of Insurance, and the IRO within one working day of the decision to reverse the Adverse Determination. Upon receiving that notification from Us, the IRO will terminate the external review.

#### **Notice of Independent External Review Determination**

Within forty-five (45) days of receiving the request for review, the IRO will decide whether to uphold or reverse Our Adverse Determination and send written notice of that decision to You, Your Physician, Us, and the Department of Insurance. The decision of the IRO is binding.

If the IRO reverses Our Adverse Determination and the review was concurrent or prospective, We will approve coverage within one (1) working day of receiving the IRO's decision. If the IRO reverses Our Adverse Determination and the review was retrospective, We will approve Benefits within five (5) working days and notify You within one (1) working day of that approval. Benefits will be provided based on the terms and conditions of Your plan.

#### **EXPEDITED INDEPENDENT EXTERNAL REVIEW**

##### **Expedited Independent External Review Process**

You, or Your designated representative may request an expedited independent external review if You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize Your life, health, or ability to regain maximum function, involve life threatening conditions, prescription drugs, intravenous infusions, or create an imminent and substantial limitation to Your ability to live independently. The review request must include a Physician's certification that Your medical condition meets this requirement. The request may be made simultaneously with an internal expedited appeal request.

Your request must be submitted to Us in writing. You must also include a signed consent form, authorizing Us to disclose protected health information, including medical records, pertinent to the external review. You may include with Your request new information, if it is significantly different from the information provided or considered during the internal review process.

We will forward a copy of Your request and the documents and information We considered in making Our Adverse Determination to the IRO within one (1) working day.

##### **Notice of Expedited Independent External Review Determination**

Within seventy-two (72) hours of receiving the request for an expedited review, the IRO will decide whether to uphold or reverse Our Adverse Determination and send written notice of that decision to You, Your Physician, the Department of Insurance, and Us. The decision of the IRO is binding. If the preceding initial notice is not provided in writing, the IRO will provide a formal written confirmation within forty-eight (48) hours of the initial notice.

If the IRO reverses our determination, We will reverse any Benefit determinations immediately upon notification and provide a written notification of Benefits within one (1) working day. Benefits will be provided based on the terms and conditions of Your plan.

##### **Retaliatory Action Prohibited**

We will not refuse to renew or cancel Your coverage if You have filed a complaint against Us or appealed a decision.

We will not refuse to renew or terminate a contract against a Physician or Provider because the Physician or Provider has, on behalf of a **Covered Person**, reasonably filed a complaint against Us or appealed a decision against us.

**Important Notice – Claims Disputes**

Should a dispute concerning a claim arise, call Us at 1-844-926-4524. If the dispute is not resolved, You may contact the:

Texas Department of Insurance at 1-800-578-4677, [www.tdi.texas.gov](http://www.tdi.texas.gov) or:  
333 Guadalupe, Austin, TX 78701; PO Box 149104, Austin, TX 78714-9104

## **Section 13 – EOC and Rate Changes**

### **CHANGES TO THIS EOC**

We may change Your EOC by adding Amendments. Amendments are legal documents that change certain parts of the EOC. 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 EOC depends on who is covered by the EOC. If You change who is covered under the EOC, the monthly premium will change as of the effective date of the change in enrollment.

### **CHANGES TO PREMIUM CHARGE**

Your Premium charges may change as permitted by law. Premiums will not change more than once a year unless there is a change to who is enrolled, You choose a different plan during a Special Enrollment Period, or if you move. We will provide at least sixty (60) days notice to You in the event of a premium change.

### **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 EOC**

If You do not take action to cancel or change Your plan or if we have not been otherwise notified, Your EOC 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. In the event of a rate increase, We will provide written notice of the premium change at least 60 days before the change takes effect.

## Section 14 – Definitions

### **Accidental Injury means:**

- Accidental bodily injury resulting, directly and independently of all other causes, an initial necessary care provided by a Physician or Other Professional provider

**Acquired Brain Injury** - a neurological insult to the brain, which is not hereditary, congenital or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior

**Adverse Determination** - a determination by Us that health care services provided or proposed to be provided to a Covered Person are not medically necessary or are experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. In the case of a prescription drug, it is an Adverse Determination if We refuse to provide benefits if the drug is not included in Our Formulary and Your physician has determined that the drug is Medically Necessary.

**Allowable Amount** – the maximum amount determined by Us to be paid to a Provider for Covered Health Services. This amount may be the Usual and Customary rate, or a rate agreed upon between the Provider or Facility and Us.

**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 EOC to determine whether or not Your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

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

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

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

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

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

- natural child
- stepchild
- legally adopted child
- foster child
- child placed for adoption, including a child who is a subject of a suit of adoption.
- 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
- grandchild who is dependent of the Covered Person for tax purposes at the time of application for coverage

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

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

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

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

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

**Percentage Copayment** – the percentage of any Allowed Amount that You are required to pay for certain Covered Health Services.

**Complications of Pregnancy** – 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.

Complication of Pregnancy will be treated on the same basis as treatment for any other sickness.

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

**Congenital Anomaly** – physical developmental defect that is present at the time of birth.

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

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

**Cost Sharing** - means the Copayment, Percentage Copayment, Deductible and any amounts exceeding Benefit Limits that a covered person will incur as an expense for Covered Services and Pharmacy Benefits.

**Covered Health Service(s)** – health services, including services, supplies, or Pharmaceutical Products, that We determine to be all of the following:

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

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

**Custodial Care** – services that are any of the following:

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

**Days' Supply Limit** – number of days of therapy You can receive for each prescription filled and re-filled under this benefit. At a Retail Pharmacy, You can receive up to a 90 consecutive day supply of a medication for each fill or re-fill. At a Mail Order Pharmacy, You can receive up to a 90 consecutive day supply of all medication except Specialty Drugs for which You may receive a 30 consecutive day supply for each prescription filled and re-filled, depending on the medication. These supplies may be reduced by Your prescriber, pharmacist, or state laws impacting Your prescription medication.

**Dependent** – 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.

**Diagnostic Imaging Provider** - a health care provider who performs a Covered Health Service on a Covered Person using magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), or any hybrid technology that combines any of those imaging modalities, or interprets imaging produced by such methods.

**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 EOC.

**Emergency Care** – 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.
- Serious jeopardy to the health of a fetus.
- With respect to a pregnant woman who is having contractions, either of the following:
  - Inadequate time to affect a safe transfer of a pregnant woman to another Hospital before delivery.
  - The transfer to another Hospital may place the health of the woman or unborn child in serious jeopardy.

**Emergency Health Services** – health care services and supplies necessary for the treatment of an Emergency, including a medical screening examination that is within the capability of the Emergency department of a Hospital or an independent freestanding emergency department equivalent to 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 EOC.

**Evidence of Coverage (“EOC”) or Plan**– the entire agreement issued to the enrolling Subscriber that includes all of the following:

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

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

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

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

**Facility** – an inpatient or outpatient hospital or freestanding surgical institution.

**Family Annual Deductible** – two times the Annual Deductible for an individual subscriber.

**Formulary/Formulary Drugs** – 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. Drugs that have been removed from the Formulary will continue to be paid at the Formulary rate until Your plan renews.

**Generic** – a Prescription Drug Product that is 1) Chemically Equivalent to a Brand Name drug, or (2) 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. 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.

**Health Status Related Factor** means:

- Health status;
- Medical condition, including both physical and mental illness;
- Claims experience;
- Receipt of health care;
- Medical history;

- Genetic information;
- Evidence of insurability, including conditions arising out of acts of family violence; and
- Disability

**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.

**Health Services** – skilled nursing by a registered nurse or a licensed vocational nurse under the supervision of at least one registered nurse and at least one physician; physical, occupational, speech, or respiratory therapy; the services of a home health aide under the supervision of a registered nurse; and the furnishing of medical equipment and supplies other than drugs or medicines.

**Home Health Agency** – program or organization authorized by law to provide health care services in the home and is licensed by the Texas Department of Human Services under Chapter 142, Health and Safety Code

**Home Health Services** – the provision of health services for payment or other consideration in a patient’s residence under a plan or care that is: established, approved in writing, and reviewed at least every two months by the attending physician; and certified by the attending physician as necessary for medical purposes.

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

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

**Inherited Enzymatic Disorder** – 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
- Propionic 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** – uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

**Intermediate Care** – Mental Health/Substance Abuse treatment that encompasses the following:

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

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

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

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

**Laboratory Service Provider** - an accredited facility in which a specimen taken from a human body is interpreted and pathological diagnoses are made, or a physician who makes an interpretation of or diagnosis based on a specimen or information provided by a laboratory based on a specimen.

**Mail Order Pharmacy** – 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** – list of Generic Prescription Drug Products along with established prices that Our Pharmacy Services Vendor has created. The list is maintained by Our Pharmacy Services Vendor and We use a list to price most of the Generic medications available under this benefit. This list is subject to periodic review and modification.

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

- Obtained through a pharmacy.
- Specifically designated and manufactured for the treatment of Inherited Enzymatic Disorders caused by gene defects involved in the metabolism of amino, organic, and fatty

- acids and for which medically standard methods of diagnosis, treatment, and monitoring exist.
- Specifically processed or formulated to be deficient in one or more nutrients and are able to be consumed or administered internally either via tube or oral route under the direction of a Physician.

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

**Medically Necessary/Medical Necessity** – a service, procedure or intervention which is recommended by a Physician to treat a medical condition which is known to be effective in improving health outcomes and is the most appropriate supply or level of service considering the Benefits and harms to the patient.

We use these terms to help us determine whether a particular service or supply will be covered. When possible, We develop written criteria (called medical criteria) that We use to determine Medical Necessity. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that We make available to the medical community and Covered Persons. We do this so that You and Your providers will know in advance, when possible, what We will pay for. If a service or supply is not Medically Necessary according to one of our published medical criteria policies, We will not pay for it. If a service or supply is not addressed by one of our published medical criteria policies, We will consider it to be Medically Necessary only if we determine that it is:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of Your medical condition;
- Provided for the diagnosis or direct care and treatment of Your medical condition;
- In accordance with standards of good medical practice accepted by the organized medical community;
- Not primarily for the convenience and/or comfort of You, Your family, Your physician, or another provider of services;
- Not “investigational”; and
- Performed in the least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A “setting” may be Your home, a physician’s office, an ambulatory surgical facility, a hospital’s outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only Your medical condition is considered in deciding which setting is Medically Necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As Your medical condition changes, the setting You need may also change. Ask Your physician if any of Your services can be performed on an outpatient basis or in a less costly setting.

It is important for You to remember that when We make medical necessity determinations, We are making them solely for the purpose of determining whether to pay for a medical service or supply. All decisions concerning Your treatment must be made solely by Your attending physician and other medical providers.

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

**Mental Disorder** – includes but is not limited to post-traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, and agoraphobia with panic disorder, anorexia nervosa, bulimia nervosa, and general anxiety disorder. For the purpose of this coverage, Mental Disorder may also include other diagnoses made by an appropriately licensed health professional and/or approved by Us.

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

**Mental Illness** – mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under this EOC.

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

**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:

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

**Network Provider or Participating Provider** – 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** – 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** – 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** – 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 EOC.

**Orthotic Device** – a custom-fitted or custom fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.

**Out-of-Pocket Maximum** – maximum amount of Deductible, Percentage Copayment, or Copayments You pay every calendar year.

Refer to the Schedule of Benefits (Who Pays What) section of this EOC to determine whether or not Your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

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

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

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

**Note:** Other providers may include audiologist, certified respiratory care practitioner, chiropractor, clinical social worker, dentist, dietitian, dispensing optician, marriage, family and child counselor, mental health clinical nurse Specialist, nurse midwife, nurse practitioner, obstetrician/gynecologist, occupational therapist, optometrist, therapeutic optometrist, ophthalmologist 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 EOC.

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

**Pre-authorization** – A determination by Us that health care services proposed to be provided to a Covered Person are Medically Necessary and appropriate.

**Pregnancy** – includes all of the following:

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

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

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

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

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

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

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

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

**Prosthetic Device** – an artificial device designed to replace, wholly, or partly an arm or leg.

**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** – 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.

**Reconstructive Surgery for Craniofacial Abnormalities** - surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

**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 EOC on behalf of the child(ren).

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

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

**Semi-private Room** – 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.

**Serious Mental Illness** – the following conditions as described in the current Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association: schizophrenia, schizoaffective disorder (bipolar or depressive), bipolar disorders (hypomanic, manic, depressive, and mixed), major depressive disorder (single episode or recurrent), obsessive-compulsive disorders, and paranoid and other psychotic disorders.

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

**Sickness** – Physical disease, physical illness and Pregnancy.



**Skilled Nursing Facility** – Hospital or nursing facility that is licensed and operated as required by law.

**Specialist Physician** – 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** – Eligible Person who is properly enrolled under this EOC. The Subscriber is the person (who is not a Dependent) on whose behalf this EOC 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.

**Teledentistry or Teledentistry Dental Service** – a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

**Telehealth or Telehealth Service** – a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

**Telemedicine or Telemedicine Medical Service** – a health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

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

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

**Usual and Customary Charge** – median rate paid for similar healthcare services within the surrounding geographic area in which the charges were incurred. The surrounding geographic area may be determined by the type of service and the access to that service in the geographic region.

## Section 15 – Notices of Certain Mandatory Benefits

This notice is to advise you of certain coverage and/or benefits provided by your contract with Bright Health.

### Mastectomy or Lymph Node Dissection

**Minimum Inpatient Stay:** If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

- (b) 48 hours following a mastectomy, and
- (c) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

**Prohibitions:** We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

If any person covered by this plan has questions concerning the above, please call Bright Health at (844) 926-4524, or write us at P.O. Box 1519, Portland, ME 04104.

### Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Enrollment

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

- (a) all stages of the reconstruction of the breast on which mastectomy has been performed;
- (b) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
- (c) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

**Prohibitions:** We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

If any person covered by this plan has questions concerning the above, please call Bright Health at (844) 926-4524, or write us at P.O. Box 1519, Portland, ME 04104.

### Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Annual

Your contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry

between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

### **Examinations for Detection of Prostate Cancer**

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

- (a) a physical examination for the detection of prostate cancer; and
- (b) a prostate-specific antigen test for each covered male who is:
  - (1) at least 50 years of age; or
  - (2) at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by this plan has questions concerning the above, please call Bright Health at (844) 926-4524, or write us at P.O. Box 1519, Portland, ME 04104.

### **Inpatient Stay following Birth of a Child**

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- (a) 48 hours following an uncomplicated vaginal delivery, and
- (b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for postdelivery care. Postdelivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

**Prohibitions.** We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (f) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

If any person covered by this plan has questions concerning the above, please call Bright Health at (844) 926-4524 or write us at P.O. Box 1519, Portland, ME 04104.

### **Coverage for Tests for Detection of Colorectal Cancer**

Benefits are provided, for each person enrolled in the plan who is 45 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include:

- (a) All colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future; and

- (b) an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

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

If any person covered by this plan has questions concerning the above, please call Bright Health at (844) 926-4524, or write us at P.O. Box 1519, Portland, ME 04104.

### **Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer**

Coverage is provided for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes, at a minimum, a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus and any other test or screening approved by the FDA for the detection of ovarian cancer.

## Bright HealthCare Insurance Company of Texas Service Area Map

[List of Counties]

[Map]