Bright HealthCare™

2022
Certificate of Coverage

BrightHealthCare.com

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call us at (844) 926-4524. For definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://brighthealthcare.com or call (844) 926-4524 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$7,000 Individual or $14,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,000 Individual or $14,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://brighthealthcare.com/search or call 1-855-827-4448 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

* For more information about limitations and exceptions, see the plan or policy document at https://www.brighthealthcare.com.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance; deductible applies	Not Covered	None
	Specialist visit	0% coinsurance; deductible applies	Not Covered	None
	Preventive care/screening/ immunization	No charge; deductible does not apply.	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Labs - 0% coinsurance; deductible applies X-rays - 0% coinsurance; deductible applies	Not Covered	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance; deductible applies	Not Covered	Services require pre-authorization.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at https://brighthealthcare.com	Generic drugs (Tier 1)	0% coinsurance; deductible applies	Not Covered	Copay shown is for a 30-day supply. You can receive up to a 90-day supply (retail prescription); 31-90 day supply (mail order prescription). Mail order copay is 2.5 times the retail copay when a 90 day supply is received.
	Preferred brand drugs (Tier 2)	0% coinsurance; deductible applies	Not Covered	Pre-authorization may be required, or services not covered. Cost sharing for any prescription drugs obtained through the use of a discount card or coupon provided by a prescription drug manufacturer will not apply

* For more information about limitations and exceptions, see the plan or policy document at https://www.brighthealthcare.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay	
	Non-preferred brand drugs (Tier 3)	0% coinsurance; deductible applies	Not Covered	toward any deductible or the out-of-pocket limit. Cost Sharing for covered prescription drugs is limited to be no more than the pharmacy's retail price.
	Specialty drugs (Tier 4)	0% coinsurance; deductible applies	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance; deductible applies	Not Covered	Services may require pre-authorization.
	Physician/surgeon fees	0% coinsurance; deductible applies	Not Covered	Services may require pre-authorization.
If you need immediate medical attention	Emergency room care	0% coinsurance; deductible applies	0% coinsurance; deductible applies	Copay is waived if you are admitted.
	Emergency medical transportation	0% coinsurance; deductible applies	0% coinsurance; deductible applies	None
	Urgent care	0% coinsurance; deductible applies	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance; deductible applies	Not Covered	Services require pre-authorization.
	Physician/surgeon fees	0% coinsurance; deductible applies	Not Covered	Services require pre-authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance; deductible applies	Not Covered	Services may require pre-authorization.
	Inpatient services	0% coinsurance; deductible applies	Not Covered	Services require pre-authorization.
If you are pregnant	Office visits	No charge	Not Covered	None

* For more information about limitations and exceptions, see the plan or policy document at https://www.brighthealthcare.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay	
	Childbirth/delivery professional services	0% coinsurance; deductible applies	Not Covered	Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery require pre-authorization.
	Childbirth/delivery facility services	0% coinsurance; deductible applies	Not Covered	
If you need help recovering or have other special needs	Home health care	0% coinsurance; deductible applies	Not Covered	Limited to 100 visits per calendar year for Home Health and Private-duty nursing. Services require pre-authorization.
	Rehabilitation services	0% coinsurance; deductible applies	Not Covered	Services require pre-authorization.
	Habilitation services	0% coinsurance; deductible applies	Not Covered	Services require pre-authorization.
	Skilled nursing center	0% coinsurance; deductible applies	Not Covered	Limited to 100 days per calendar year. Services require pre-authorization.
	Durable medical equipment	0% coinsurance; deductible applies	Not Covered	Services may require pre-authorization.
	Hospice services	No charge; deductible does not apply.	Not Covered	Services require pre-authorization.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply.	Not Covered	Limited to 1 eye exam per calendar year, through the end of the month in which the dependent child turns 19.
	Children's glasses	No charge; deductible does not apply.	Not Covered	Limited to 1 pair of glasses including standard frames and standard lenses, or a one-year supply of contact lenses through the end of the month in which the member turns 19.
	Children's dental checkups	No charge; deductible does not apply.	Not Covered	Includes diagnostic and preventive services through the end of the month in which the member turns 19. Refer to the policy for covered services and limitations.

* For more information about limitations and exceptions, see the plan or policy document at https://www.brighthealthcare.com.

Excluded Services & Other Covered Services

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Chiropractic Care • Cosmetic Surgery • Dental Care (Adult)	• Hearing Aids • Long Term Care • Non-emergency care when traveling outside the U.S.	• Routine eye care (Adults) • Routine foot care, unless medically necessary for diabetes • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • Acupuncture	• Bariatric Surgery • Infertility treatment	• Private-duty nursing (combined with Home Health) • Routine foot care (for diabetes)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Managed Health Care at 1 (888) 466-2219 or www.dmhc.ca.gov, and Covered California at 1 (800) 300-1506 or coveredca.com. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1 (800) 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Managed Health Care at 1 (888) 466-2219 or https://www.dmhc.ca.gov/.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Not Applicable**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al (844) 926-4524.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (844) 926-4524.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (844) 926-4524.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (844) 926-4524.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at https://www.brighthealthcare.com.

About these Coverage Examples

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$7,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic test (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$7,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,060**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$7,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic test (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$7,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Schedule of Benefits
Bronze HDHP HMO Plan
(Who Pays What)
From 01/01/2022 through 12/31/2022

THIS SCHEDULE OF BENEFITS IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

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

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

You can review our provider network online at www.brighthealthcare.com, or You can contact Bright HealthCare Customer Service at (844) 926-4524 to locate a provider or request a paper copy of the provider directory.

Deductible
A Deductible is the amount that a Covered Person must pay before Bright HealthCare pays any benefits for Covered Health Services. The Deductible amount does not include Coinsurance, Copayment, or non-covered charges.

Copayment
A Copayment is a specific dollar amount that You must pay for certain Covered Health Services.

Coinsurance
A Coinsurance is a percentage of charges for Covered Health Services that must be paid by a Covered Person. Coinsurance amounts do not include Deductible, Copayment, or charges for non-covered services.

Maximum Out-of-Pocket
The Maximum Out-of-Pocket is the maximum dollar amount that a Covered Person may pay in combined Deductible, Copayment and Coinsurance amounts per Calendar Year. All Deductible, Copayment and Coinsurance payments for In-Network Covered Health Services will apply to the Maximum Out-of-Pocket amount. Once the Maximum Out-of-Pocket amount has been met for a Covered Person, the Covered Person will have no further obligation to pay Deductible, Copayment or Coinsurance amounts for Covered Health Services received from a participating Bright HealthCare Provider for the remainder of the Calendar Year. Refer to Your Policy to see how charges from Non-Network Providers may be covered.

For policies with two or more people, each person's Individual Out-of-Pocket maximum applies to the Family Maximum Out-of-Pocket. Once a Covered Person has met his or her Maximum Out-of-Pocket, covered In-Network services will be paid at 100% for that person. Once two (2) or more people's combined Out-of-Pocket expenses reach the Family Maximum Out-of-Pocket, covered In-Network services for the family will be paid at 100%.

Limitations/Exclusions
Some limitations and exclusions are listed in this Schedule of Benefits. Refer to the Benefits/Coverage (What is Covered) and Limitations/Exclusions (What is Not Covered) sections of Your policy for a more comprehensive listing and description of services or items that are limited or not covered by the Plan.

General Cost Share & Features	In Network	Non Network
Deductible: - Per Plan Year *Some services do not apply to the deductible, as indicated below.*	$7,000/Individual; $14,000 Family	Not covered

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Schedule of Benefits
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General Cost Share & Features	In Network	Non Network
Out-of-Pocket Maximum: - Per Plan Year	$7,000/Individual; $14,000 Family	Not covered

Benefit	In Network	Non Network
Health care provider's office or clinic visit		
Primary care visit to treat an injury, illness, or condition	0% after deductible	Not covered
Other practitioner office visit	0% after deductible	Not covered
Specialist visit	0% after deductible	Not covered
Preventive care/screening/ immunization	No charge	Not covered

Benefit	In Network	Non Network
Tests		
Laboratory Tests	0% after deductible	Not covered
X-rays and Diagnostic Imaging	0% after deductible	Not covered
Imaging (CT/PET scans, MRIs) *Services require pre-authorization.*	0% after deductible	Not covered

Benefit	In Network Retail Pharmacy	Non Network Retail Pharmacy
Drugs to treat illness or condition *The copay or co-insurance applies to an up to 30-day prescription supply. The enrollee's cost share will be the lower of the pharmacy's retail price, or the applicable cost-share amount. Amounts paid by the enrollee will apply to the Deductible and Out-of-Pocket Maximum.*		
Tier 1	0% after deductible	Not covered
Tier 2	0% after deductible	Not covered
Tier 3	0% after deductible	Not covered
Tier 4	0% after deductible	Not covered

Benefit	In Network	Non Network
Outpatient services		
Surgery facility fee *Services require pre-authorization.*	0% after deductible	Not covered
Physician/surgeon fees *Services require pre-authorization.*	0% after deductible	Not covered
Outpatient visit	0% after deductible	Not covered

Bright HealthCare

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Benefit	In Network	Non Network
Need immediate attention		
Emergency room facility fee (waived if admitted)	0% after deductible	0% after deductible
Emergency room physician fee (waived if admitted)	0% after deductible	0% after deductible
Medical transportation (including emergency and non-emergency)	0% after deductible	0% after deductible
Urgent care	0% after deductible	0% after deductible

Benefit	In Network	Non Network
Hospital stay		
Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) *Services require pre-authorization.*	0% after deductible	Not covered
Physician/surgeon fee *Services require pre-authorization.*	0% after deductible	Not covered

Benefit	In Network	Non Network
Mental Health and Substance Abuse Services		
Mental/behavioral health and substance use disorder outpatient office visits	0% after deductible	Not covered
Mental/behavioral health and substance use disorder other outpatient items and services	0% after deductible	Not covered

Benefit	In Network	Non Network
Pregnancy		
Prenatal care and preconception visits	No charge	Not covered

Benefit	In Network	Non Network
Help recovering or other special health needs		
Home health care (cost share per visit)	0% after deductible	Not covered
Outpatient Rehabilitation and Habilitation services *Services require pre-authorization.*	0% after deductible	Not covered

Benefit	In Network	Non Network
Skilled nursing care *Services require pre-authorization.*	0% after deductible	Not covered
Durable medical equipment *Services require pre-authorization.*	0% after deductible	Not covered
Hospice service *Services require pre-authorization.*	0% after deductible	Not covered

Benefit	In Network	Non Network
Child eye care – Coverage is available through the end of the month in which the dependent child turns 19.		
Eye Exam with Dilation, as necessary - *Limited to 1 refractive eye exam per calendar year*		
	No charge	Not covered
Eyeglasses - *1 pair of glasses per year (or a 1-year supply of contact lenses in lieu of glasses)*		
Includes single vision, conventional (lined) bifocal, conventional (lined) trifocal, lenticular, and standard progressive lenses. Frames are covered in full when provider designated frames are selected.	0% after deductible	Not covered
Contact Lenses for Refraction (in lieu of contact lenses)		
Includes: • Extended wear disposables • Daily wear / disposables • Conventional • Medically Necessary contact lenses.	0% after deductible	Not covered
Low Vision Services		
Exam	0% after deductible	Not covered
Low vision aids	0% after deductible	Not covered

Benefit	In Network	Non Network
Child Dental Diagnostic and Preventive		
Oral Exam	No charge	Not covered
Preventive - Cleaning	No charge	Not covered
Preventive - X-ray	No charge	Not covered
Sealants per Tooth	No charge	Not covered
Topical Fluoride Application	No charge	Not covered

Bright HealthCare

Schedule of Benefits
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Benefit	In Network	Non Network
Space Maintainers - Fixed	No charge	Not covered

Benefit	In Network	Non Network
Child Dental Basic Services		
Restorative Procedures	20%	Not covered
Periodontal Maintenance Services	20%	Not covered

Benefit	In Network	Non Network
Child Dental Major Services		
Crowns and Casts	50%	Not covered
Endodontics	50%	Not covered
Periodontics (other than maintenance)	50%	Not covered
Prosthodontics	50%	Not covered
Oral Surgery	50%	Not covered

Benefit	In Network	Non Network
Child Orthodontics		
Medically necessary orthodontics	50%	Not covered

These endnotes and the Patient-Centered Benefit Plan Designs apply only to covered services.

Notes:

1. Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-Network services include services provided by an out-of-network provider but are approved as in-network by the issuer.
2. For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
3. Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
4. For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
5. For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2022 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
6. Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the $45 copayment, the lesser amount is the applicable cost-sharing amount.

7. For the non-HDHP Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient Mental Health/Substance Use Disorder visits.
8. Member cost-share for oral anti-cancer drugs shall not exceed $250 for a script of up to 30 days per state law (Health and Safety Code § 1397.656; Insurance Code § 10123.206).
9. In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.
10. For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
11. As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
12. A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2022 Dental Copay Schedule.
13. Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
14. Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient- Centered Benefit Plan Designs.
15. Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
16. Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
17. Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
18. The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
19. The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
20. The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility.
21. Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be different but not more than those listed in these patient-centered benefit plan designs if necessary for compliance with MHPAEA.
22. Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.
23. Drug tiers are defined as follows:

Tier	Definition

1	1) Most generic drugs and low-cost preferred brands.
2	1) Non-preferred generic drugs;
	2) Preferred brand name drugs; and
	3) Any other drugs recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or;
	2) Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Drugs that are biologics and drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies;
	2) Drugs that require the enrollee to have special training or clinical monitoring;
	3) Drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) net of rebates for a one-month supply.

Some drugs may be subject to zero cost-sharing under the preventive services rules.

24. Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.
25. A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
26. The health issuer may not impose a member cost share for Diabetes Self- Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
27. The cost sharing for hospice services applies regardless of the place of service.
28. For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
29. For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.
30. For any benefit plan design in which a designation of Individual-Only or CCSB- Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.
31. The Bronze and Bronze HDHP are contingent upon meeting the actuarial value requirements in state law. The out-of-pocket maximum in the Bronze HDHP shall be equal to the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2022 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.

LIBERTY Dental Plan of California, Inc.
Children's Dental HMO - Bright HealthCare IND Bronze 60 HDHP

Individual Out of Pocket Maximum: $7,000 per 2022 Calendar Year
Family Out of Pocket Maximum: $14,000 per 2022 Calendar Year

✓ Members must visit a LIBERTY Dental Plan contracted dental office to utilize covered benefits. Your dental office will determine a treatment plan or will initiate the specialty referral process with LIBERTY Dental Plan if the recommended covered services are medically necessary and outside the scope of a general dentist.

✓ This Benefit Schedule represents the Children's Dental HMO benefits covered as part of your Health Plan offered through Bright HealthCare. Any Co-payment for covered dental services will accrue towards the Health Plan's Calendar Year Out-of-Pocket Maximum (which is provided above for your reference). To verify your Out-of-Pocket Maximum you can refer to your Health Plan's Evidence of Coverage booklet, visit your health plan's website at www.brighthealthcare.com or call Member Services at 1.855.827.4448 (toll-free).

✓ Once your Out-of-Pocket costs for all Medical and Dental covered services reach the combined Out-of-Pocket Maximum, you cannot be charged for covered dental services you receive for the remainder of the Calendar year. The LIBERTY Dental Plan contracted dental office will be paid for covered services as contracted directly by LIBERTY. Charges for optional and non-covered services are not included in the calculation for the combined out-of-pocket maximum and would remain your financial responsibility. In a plan with two or more members, the first family Member to meet the individual Out-of-Pocket Maximum cannot be charged for covered services for the remainder of the Calendar year. The family Out-of-Pocket Maximum is met by combining eligible expenses of two or more covered family Members.

✓ This Benefit Schedule does not guarantee benefits. All services are subject to eligibility, exclusions and limitations and must be determined to be medically necessary at the time you receive the service. Additional requests, beyond the stated frequency limitations shall be considered for prior authorization when documented dental necessity is provided as required by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.

✓ Dental procedures not listed on this Benefit Schedule may be available at the dental office's usual and customary fees.

CDT Code	Description	Member Responsibility	Limitation
DIAGNOSTIC & PREVENTIVE SERVICES			
	Diagnostic Services		
D0120	Periodic oral evaluation	no charge	1 (D0120) every 6 months per provider
D0140	Limited oral evaluation	no charge	1 (D0140) per patient per provider
D0145	Oral evaluation under age 3	no charge	
D0150	Comprehensive oral evaluation	no charge	1 (D0150) per patient per provider for initial evaluation
D0160	Oral evaluation, problem focused	no charge	1 (D0160) per patient per provider
D0170	Re-evaluation, limited, problem focused	no charge	up to 6 of (D0170, D0171)in a 3 month period, no more than 12 in a 12 months
D0171	Re-evaluation, post operative office visit	no charge	
D0180	Comprehensive periodontal evaluation	no charge	only be billed as D0150
D0190	Screening of a patient	not covered	
D0191	Assessment of a patient	not covered	
D0210	Intraoral, complete series of radiographic images	no charge	1 of (D0210, D0709) every 36 months per provider
D0220	Intraoral, periapical, first radiographic image	no charge	20 of (D0220, D0230, D0707) 12 months, per provider
D0230	Intraoral, periapical, each add 'l radiographic image	no charge	
D0240	Intraoral, occlusal radiographic image	no charge	2 of (D0240, D0706) every 6 months per provider
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	no charge	1 (D0250) per date of service
D0251	Extra-oral posterior dental radiographic image	no charge	1 of (D0251, D0705) per date of service
D0270	Bitewing, single radiographic image	no charge	1 of (D0270, D0708) per date of service
D0272	Bitewings, two radiographic images	no charge	1 (D0272) every 6 months per provider
D0273	Bitewings, three radiographic images	no charge	downcode to D0270 and D0272
D0274	Bitewings, four radiographic images	no charge	1 (D0274) every 6 months per provider, age 10 and over
D0277	Vertical bitewings, 7 to 8 radiographic images	no charge	downcode to D0274
D0310	Sialography	no charge	
D0320	TMJ arthrogram, including injection	no charge	3 (D0320) per date of service
D0322	Tomographic survey	no charge	2 (D0322) every 12 months per provider
D0330	Panoramic radiographic image	no charge	1 of (D0330, D0701) every 36 months per provider
D0340	2D cephalometric radiographic image, measurement and analysis	no charge	2 of (D0340, D0702) every 12 months per provider
D0350	2D oral/facial photographic image, intra-orally/extra-orally	no charge	4 of (D0350, D0703) per date of service
D0351	3D photographic image	no charge	
D0419	Assessment of salivary flow by measurement	not covered	
D0431	Adjunctive pre-diagnostic test	not covered	
D0460	Pulp vitality tests	no charge	
D0470	Diagnostic casts	no charge	1 (D0470) per provider, only a benefit with covered Orthodontic services, for permanent dentition
D0502	Other oral pathology procedures, by report	no charge	
D0601	Caries risk assessment and documentation, low risk	no charge	
D0602	Caries risk assessment and documentation, moderate risk	no charge	
D0603	Caries risk assessment and documentation, high risk	no charge	
D0701	Panoramic radiographic image, image capture only	no charge	1 of (D0330, D0701) every 36 months per provider
D0702	2-D cephalometric radiographic image, image capture only	no charge	2 of (D0340, D0702) every 12 months per provider
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally, image capture only	no charge	4 of (D0350, D0703) per date of service
D0704	3-D photographic image, image capture only	no charge	
D0705	Extra-oral posterior dental radiographic image, image capture only	no charge	1 of (D0251, D0705) per date of service
D0706	Intraoral, occlusal radiographic image, image capture only	no charge	2 of (D0240, D0706) every 6 months per provider
D0707	Intraoral, periapical radiographic image, image capture only	no charge	20 of (D0220, D0230, D0707) every 12 months, per provider
D0708	Intraoral, bitewing radiographic image, image capture only	no charge	1 of (D0270, D0708) per date of service
D0709	Intraoral, complete series of radiographic images, image capture only	no charge	1 of (D0210, D0709) every 36 months per provider
D0999	Unspecified diagnostic procedure, by report	no charge	
	Preventive Services		
D1110	Prophylaxis, adult	no charge	1 of (D1110, D1120, D4346) every 6 months
D1120	Prophylaxis, child	no charge	
D1206	Topical application of fluoride varnish	no charge	1 of (D1206, D1208) every 6 months
D1208	Topical application of fluoride, excluding varnish	no charge	
D1310	Nutritional counseling for control of dental disease	no charge	
D1320	Tobacco counseling, control/prevention oral disease	no charge	
D1321	Counseling for the control and prevention of adverse oral, behavioral, health effects associated with high-risk substance use	no charge	
D1330	Oral hygiene instruction	no charge	
D1351	Sealant, per tooth	no charge	1 of (D1351,D1352) every 36 months 1st, 2nd, 3rd molars
D1352	Preventive resin restoration, permanent tooth	no charge	
D1353	Sealant repair, per tooth	no charge	1 (D1353) every 36 months 1st, 2nd, 3rd molars
D1354	Application of caries arresting medicament, per tooth	no charge	1 (D1354) per tooth every 6 months, subject to medical necessity review for the first treatment only

LIBERTY Dental Plan of California, Inc.
Children's Dental HMO - Bright HealthCare IND Bronze 60 HDHP

CDT Code	Description	Member Responsibility	Limitation
	Preventive Services (continued)		
D1355	Caries preventive medicament application, per tooth	no charge	1 (D1355) per tooth every 6 months, subject to medical necessity review for the first treatment only
D1510	Space maintainer, fixed, unilateral, per quadrant	no charge	1 of (D1510, D1520) per quadrant per patient, under age 18
D1516	Space maintainer, fixed, bilateral, maxillary	no charge	1 of (D1516, D1526) under age 18
D1517	Space maintainer, fixed, bilateral, mandibular	no charge	1 of (D1517, D1527) under age 18
D1520	Space maintainer, removable, unilateral, per quadrant	no charge	1 of (D1510, D1520) per quadrant per patient under age 18
D1526	Space maintainer, removable, bilateral, maxillary	no charge	1 of (D1516, D1526) under age 18
D1527	Space maintainer, removable, bilateral, mandibular	no charge	1 of (D1517, D1527) under age 18
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	no charge	1 of (D1551, D1552) per arch every 12 months under age 18
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	no charge	
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	no charge	1 (D1553) per quad every 12 months under age 18
D1556	Removal of fixed unilateral space maintainer, per quadrant	no charge	
D1557	Removal of fixed bilateral space maintainer, maxillary	no charge	
D1558	Removal of fixed bilateral space maintainer, mandibular	no charge	
D1575	Distal shoe space maintainer, fixed, per quadrant	no charge	
	Adjunctive General Services		
D9110	Palliative (emergency) treatment, minor procedure	no charge	1 (D9110) per date of service
D9311	Consultation with a medical health care professional	no charge	
D9995	Teledentistry, synchronous; real-time encounter	no charge	
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review	no charge	
D9997	Dental case management, patients with special health care needs	no charge	
D9999	Unspecified adjunctive procedure, by report	no charge	
BASIC SERVICES			
	Restorative Services		
D2140	Amalgam, one surface, primary or permanent	20%	primary teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 12 months permanent teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months
D2150	Amalgam, two surfaces, primary or permanent	20%	
D2160	Amalgam, three surfaces, primary or permanent	20%	
D2161	Amalgam, four or more surfaces, primary or permanent	20%	
D2330	Resin-based composite, one surface, anterior	20%	
D2331	Resin-based composite, two surfaces, anterior	20%	
D2332	Resin-based composite, three surfaces, anterior	20%	
D2335	Resin-based composite, four or more surfaces, involving incisal angle	20%	
D2390	Resin-based composite crown, anterior	20%	primary teeth - 1 (D2390) per tooth every 12 months permanent teeth - 1 (D2390) per tooth every 36 months
D2391	Resin-based composite, one surface, posterior	20%	primary teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 12 months permanent teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months
D2392	Resin-based composite, two surfaces, posterior	20%	
D2393	Resin-based composite, three surfaces, posterior	20%	
D2394	Resin-based composite, four or more surfaces, posterior	20%	
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	20%	1 (D2910) per tooth every 12 months, per provider
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	20%	
D2920	Re-cement or re-bond crown	20%	after 12 months of initial placement with same provider
D2921	Reattachment of tooth fragment, incisal edge or cusp	20%	
D2928	Prefabricated porcelain/ceramic crown, permanent tooth	20%	1 of (D2928, D2931) per tooth every 36 months
D2929	Prefabricated porcelain/ceramic crown, primary tooth	20%	1 of (D2929, D2930) per tooth every 12 months
D2930	Prefabricated stainless steel crown, primary tooth	20%	
D2931	Prefabricated stainless steel crown, permanent tooth	20%	1 of (D2928, D2931) per tooth every 36 months
D2932	Prefabricated resin crown	20%	primary - 1 of (D2932, D2933) per tooth every 12 months permanent - 1 of (D2932, D2933) per tooth every 36 months
D2933	Prefabricated stainless steel crown with resin window	20%	
D2940	Protective restoration	20%	1 (D2940) per tooth every 6 months, per provider
D2941	Interim therapeutic restoration, primary dentition	20%	
D2949	Restorative foundation for an indirect restoration	20%	
D2950	Core buildup, including any pins when required	20%	
D2951	Pin retention, per tooth, in addition to restoration	20%	1 (D2951) per tooth
D2952	Post and core in addition to crown, indirectly fabricated	20%	1 (D2952) per tooth
D2953	Each additional indirectly fabricated post, same tooth	20%	
D2954	Prefabricated post and core in addition to crown	20%	1 (D2954) per tooth
D2955	Post removal	20%	
D2957	Each additional prefabricated post, same tooth	20%	
D2971	Additional procedure to construct new crown, existing partial denture frame	20%	
D2980	Crown repair necessitated by restorative material failure	20%	after 12 months of initial crown placement with same provider
D2999	Unspecified restorative procedure, by report	20%	
	Periodontal Services		
GUIDELINE: No more than two (2) quadrants of periodontal scaling and root planing per appointment/ per day are allowable.			
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	20%	1 of (D4341, D4342) per site quad, every 24 months, age 13 and over
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	20%	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis, subsequent visit	20%	
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	20%	1 of (D1110, D1120, D4346) every 6 months
D4381	Localized delivery of antimicrobial agent/per tooth	20%	
D4910	Periodontal maintenance	20%	1 (D4910) every 3 months
MAJOR SERVICES			
	Major Restorative Services		
D2542	Onlay, metallic, two surfaces	not covered	
D2543	Onlay, metallic, three surfaces	not covered	
D2544	Onlay, metallic, four or more surfaces	not covered	
D2642	Onlay, porcelain/ceramic, two surfaces	not covered	
D2643	Onlay, porcelain/ceramic, three surfaces	not covered	
D2644	Onlay, porcelain/ceramic, four or more surfaces	not covered	
D2662	Onlay, resin-based composite, two surfaces	not covered	

CDT Code	Description	Member Responsibility	Limitation
	Major Restorative Services (continued)		
D2663	Onlay, resin-based composite, three surfaces	not covered	
D2664	Onlay, resin-based composite, four or more surfaces	not covered	
D2710	Crown, resin-based composite (indirect)	50%	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over
D2712	Crown, ¾ resin-based composite (indirect)	50%	
D2720	Crown, resin with high noble metal	not covered	
D2721	Crown, resin with predominantly base metal	50%	
D2722	Crown, resin with noble metal	not covered	
D2740	Crown, porcelain/ceramic	50%	
D2750	Crown, porcelain fused to high noble metal	not covered	
D2751	Crown, porcelain fused to predominantly base metal	50%	
D2752	Crown, porcelain fused to noble metal	not covered	
D2753	Crown, porcelain fused to titanium and titanium alloys	not covered	
D2780	Crown, ¾ cast high noble metal	not covered	
D2781	Crown, ¾ cast predominantly base metal	50%	
D2782	Crown, ¾ cast noble metal	not covered	
D2783	Crown, ¾ porcelain/ceramic	50%	
D2790	Crown, full cast high noble metal	not covered	
D2791	Crown, full cast predominantly base metal	50%	
D2792	Crown, full cast noble metal	not covered	
D2794	Crown, titanium and titanium alloys	not covered	
	Endodontic Services		
D3110	Pulp cap, direct (excluding final restoration)	50%	
D3120	Pulp cap, indirect (excluding final restoration)	50%	
D3220	Therapeutic pulpotomy (excluding final restoration)	50%	1 (D3220) per primary tooth
D3221	Pulpal debridement, primary and permanent teeth	50%	1 (D3221) per tooth
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	50%	1 (D3222) per tooth
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	50%	1 of (D3230, D3240) per tooth
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	50%	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	50%	1 of (D3310, D3320, D3330) per tooth
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	50%	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	50%	
D3331	Treatment of root canal obstruction; non-surgical access	50%	
D3332	Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth	not covered	
D3333	Internal root repair of perforation defects	50%	
D3346	Retreatment of previous root canal therapy, anterior	50%	1 of (D3346-D3348) after 12 months of initial treatment
D3347	Retreatment of previous root canal therapy, premolar	50%	
D3348	Retreatment of previous root canal therapy, molar	50%	
D3351	Apexification/recalcification, initial visit	50%	1 (D3351) per tooth
D3352	Apexification/recalcification, interim medication replacement	50%	1 (D3352) per tooth
D3353	Apexification/recalcification, final visit	not covered	
D3410	Apicoectomy, anterior	50%	
D3421	Apicoectomy, premolar (first root)	50%	
D3425	Apicoectomy, molar (first root)	50%	
D3426	Apicoectomy, (each additional root)	50%	
D3430	Retrograde filling, per root	50%	
D3450	Root amputation, per root	not covered	
D3471	Surgical repair of root resorption, anterior	50%	
D3472	Surgical repair of root resorption, premolar	50%	
D3473	Surgical repair of root resorption, molar	50%	
D3910	Surgical procedure for isolation of tooth with rubber dam	50%	
D3920	Hemisection, not including root canal therapy	not covered	
D3950	Canal preparation and fitting of preformed dowel or post	not covered	
D3999	Unspecified endodontic procedure, by report	50%	
	Periodontal Services		
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	50%	1 of (D4210, D4211, D4260, D4261) per site/quad every 36 months, age 13 and over
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	50%	
D4240	Gingival flap procedure, four or more teeth per quadrant	not covered	
D4241	Gingival flap procedure, one to three teeth per quadrant	not covered	
D4249	Clinical crown lengthening, hard tissue	50%	
D4260	Osseous surgery, four or more teeth per quadrant	50%	1 of (D4210, D4211, D4260, D4261) per site/quad every 36 months, age 13 and over
D4261	Osseous surgery, one to three teeth per quadrant	50%	
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	not covered	
D4264	Bone replacement graft, retained natural tooth, each additional site	not covered	
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	50%	
D4266	Guided tissue regeneration, resorbable barrier, per site	not covered	
D4267	Guided tissue regeneration, non-resorbable barrier, per site	not covered	
D4270	Pedicle soft tissue graft procedure	not covered	
D4273	Autogenous connective tissue graft procedure, first tooth	not covered	
D4275	Non-autogenous connective tissue graft, first tooth	not covered	
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	not covered	
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	not covered	
D4920	Unscheduled dressing change (other than treating dentist or staff)	50%	1 (D4920) per patient per provider, age 13 and over
D4999	Unspecified periodontal procedure, by report	50%	
	Removable Prosthodontic Services		
D5110	Complete denture, maxillary	50%	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture - complete denture.
D5120	Complete denture, mandibular	50%	
D5130	Immediate denture, maxillary	50%	1 (D5130) per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.

CDT Code	Description	Member Responsibility	Limitation
	Removable Prosthodontic Services (continued)		
D5140	Immediate denture, mandibular	50%	1 (D5140) per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
D5211	Maxillary partial denture, resin base	50%	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture - complete denture.
D5212	Mandibular partial denture, resin base	50%	
D5213	Maxillary partial denture, cast metal, resin base	50%	
D5214	Mandibular partial denture, cast metal, resin base	50%	
D5221	Immediate maxillary partial denture, resin base	50%	1 of (D5221-D5224) per arch per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
D5222	Immediate mandibular partial denture, resin base	50%	
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	50%	
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	50%	
D5225	Maxillary partial denture, flexible base	not covered	
D5226	Mandibular partial denture, flexible base	not covered	
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	not covered	
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	not covered	
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	not covered	
D5286	Removable unilateral partial denture, one piece resin, per quadrant	not covered	
D5410	Adjust complete denture, maxillary	50%	2 of (D5410-D5422) per arch every 12 months, 1 per arch per date of service per provider
D5411	Adjust complete denture, mandibular	50%	
D5421	Adjust partial denture, maxillary	50%	
D5422	Adjust partial denture, mandibular	50%	
D5511	Repair broken complete denture base, mandibular	50%	1 (D5511) per date of service per provider, 2 every 12 months per provider
D5512	Repair broken complete denture base, maxillary	50%	1 (D5512) per date of service per provider, 2 every 12 months per provider
D5520	Replace missing or broken teeth, complete denture	50%	up to 4 (D5520) per arch per date of service per provider, 2 per arch every 12 months per provider
D5611	Repair resin partial denture base, mandibular	50%	1 (D5611) per date of service per provider, 2 every 12 months per provider
D5612	Repair resin partial denture base, maxillary	50%	1 (D5612) per date of service per provider, 2 every 12 months per provider
D5621	Repair cast partial framework, mandibular	50%	1 (D5621) per date of service per provider, 2 every 12 months per provider
D5622	Repair cast partial framework, maxillary	50%	1 (D5622) per date of service per provider, 2 every 12 months per provider
D5630	Repair or replace broken retentive clasping materials, per tooth	50%	3 (D5630) per arch per date of service per provider, 2 per arch every 12 months per provider
D5640	Replace broken teeth, per tooth	50%	4 (D5640) per arch per date of service per provider, 2 per arch every 12 months per provider
D5650	Add tooth to existing partial denture	50%	3 (D5650) per arch per provider per date of service, 1 per tooth
D5660	Add clasp to existing partial denture, per tooth	50%	3 (D5660) per date of service per provider, 2 per arch every 12 months per provider
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	not covered	
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	not covered	
D5710	Rebase complete maxillary denture	not covered	
D5711	Rebase complete mandibular denture	not covered	
D5720	Rebase maxillary partial denture	not covered	
D5721	Rebase mandibular partial denture	not covered	
D5730	Reline complete maxillary denture, direct	50%	1 of (D5730-D5761) every 12 months. Covered 6 months after initial placement of appliance if extractions were required, 12 months after initial placement of appliance if extractions were not required.
D5731	Reline complete mandibular denture, direct	50%	
D5740	Reline maxillary partial denture, direct	50%	
D5741	Reline mandibular partial denture, direct	50%	
D5750	Reline complete maxillary denture, indirect	50%	
D5751	Reline complete mandibular denture, indirect	50%	
D5760	Reline maxillary partial denture, indirect	50%	
D5761	Reline mandibular partial denture, indirect	50%	
D5850	Tissue conditioning, maxillary	50%	2 (D5850) every 36 months
D5851	Tissue conditioning, mandibular	50%	2 (D5851) every 36 months
D5862	Precision attachment, by report	50%	
D5863	Overdenture, complete, maxillary	50%	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture - complete denture.
D5864	Overdenture, partial, maxillary	50%	
D5865	Overdenture, complete, mandibular	50%	
D5866	Overdenture, partial, mandibular	50%	
D5876	Add metal substructure to acrylic full denture (per arch)	not covered	
D5899	Unspecified removable prosthodontic procedure, by report	50%	
	Maxillofacial Prosthetic Services		
D5911	Facial moulage (sectional)	50%	
D5912	Facial moulage (complete)	50%	
D5913	Nasal prosthesis	50%	
D5914	Auricular prosthesis	50%	
D5915	Orbital prosthesis	50%	
D5916	Ocular prosthesis	50%	
D5919	Facial prosthesis	50%	
D5922	Nasal septal prosthesis	50%	
D5923	Ocular prosthesis, interim	50%	
D5924	Cranial prosthesis	50%	
D5925	Facial augmentation implant prosthesis	50%	
D5926	Nasal prosthesis, replacement	50%	
D5927	Auricular prosthesis, replacement	50%	
D5928	Orbital prosthesis, replacement	50%	
D5929	Facial prosthesis, replacement	50%	
D5931	Obturator prosthesis, surgical	50%	
D5932	Obturator prosthesis, definitive	50%	
D5933	Obturator prosthesis, modification	50%	2 (D5933) every 12 months
D5934	Mandibular resection prosthesis with guide flange	50%	
D5935	Mandibular resection prosthesis without guide flange	50%	
D5936	Obturator prosthesis, interim	50%	

CDT Code	Description	Member Responsibility	Limitation
	Maxillofacial Prosthetic Services (continued)		
D5937	Trismus appliance (not for TMD treatment)	50%	
D5951	Feeding aid	50%	under age 18
D5952	Speech aid prosthesis, pediatric	50%	under age 18
D5953	Speech aid prosthesis, adult	50%	age 18 and over
D5954	Palatal augmentation prosthesis	50%	
D5955	Palatal lift prosthesis, definitive	50%	
D5958	Palatal lift prosthesis, interim	50%	
D5959	Palatal lift prosthesis, modification	50%	2 (D5959) every 12 months
D5960	Speech aid prosthesis, modification	50%	2 (D5960) every 12 months
D5982	Surgical stent	50%	
D5983	Radiation carrier	50%	
D5984	Radiation shield	50%	
D5985	Radiation cone locator	50%	
D5986	Fluoride gel carrier	50%	
D5987	Commissure splint	50%	
D5988	Surgical splint	50%	
D5991	Vesiculobullous disease medicament carrier	50%	
D5999	Unspecified maxillofacial prosthesis, by report	50%	
	Implant Services		
D6010	Surgical placement of implant body, endosteal	50%	Only a Plan Benefit when exceptional medical conditions are met
D6011	Second stage implant surgery	50%	
D6013	Surgical placement of mini implant	50%	
D6040	Surgical placement: eposteal implant	50%	
D6050	Surgical placement: transosteal implant	50%	
D6055	Connecting bar, implant supported or abutment supported	50%	
D6056	Prefabricated abutment, includes modification and placement	50%	
D6057	Custom fabricated abutment, includes placement	50%	
D6058	Abutment supported porcelain/ceramic crown	50%	
D6059	Abutment supported porcelain fused to high noble crown	50%	
D6060	Abutment supported porcelain fused to base metal crown	50%	
D6061	Abutment supported porcelain fused to noble metal crown	50%	
D6062	Abutment supported cast metal crown, high noble	50%	
D6063	Abutment supported cast metal crown, base metal	50%	
D6064	Abutment supported cast metal crown, noble metal	50%	
D6065	Implant supported porcelain/ceramic crown	50%	
D6066	Implant supported crown, porcelain fused to high noble alloys	50%	
D6067	Implant supported crown, high noble alloys	50%	
D6068	Abutment supported retainer, porcelain/ceramic FPD	50%	
D6069	Abutment supported retainer, metal FPD, high noble	50%	
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	50%	
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	50%	
D6072	Abutment supported retainer, cast metal FPD, high noble	50%	
D6073	Abutment supported retainer, cast metal FPD, base metal	50%	
D6074	Abutment supported retainer, cast metal FPD, noble	50%	
D6075	Implant supported retainer for ceramic FPD	50%	
D6076	Implant supported retainer for FPD, porcelain fused to high noble alloys	50%	
D6077	Implant supported retainer for metal FPD, high noble alloys	50%	
D6080	Implant maintenance procedures, prosthesis removed/reinserted, including cleansing	50%	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	50%	
D6082	Implant supported crown, porcelain fused to predominantly base alloys	50%	
D6083	Implant supported crown, porcelain fused to noble alloys	50%	
D6084	Implant supported crown, porcelain fused to titanium and titanium alloys	50%	
D6085	Interim implant crown	50%	
D6086	Implant supported crown, predominantly base alloys	50%	
D6087	Implant supported crown, noble alloys	50%	
D6088	Implant supported crown, titanium and titanium alloys	50%	
D6090	Repair implant supported prosthesis, by report	50%	
D6091	Replacement part of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	50%	
D6092	Re-cement or re-bond implant/abutment supported crown	50%	
D6093	Re-cement or re-bond implant/abutment supported FPD	50%	
D6094	Abutment supported crown, titanium, and titanium alloys	50%	
D6095	Repair implant abutment, by report	50%	
D6096	Remove broken implant retaining screw	50%	
D6097	Abutment supported crown, porcelain fused to titanium and titanium alloys	50%	
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	50%	
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	50%	
D6100	Surgical removal of implant body	50%	
D6110	Implant/abutment supported removable denture, maxillary	50%	
D6111	Implant/abutment supported removable denture, mandibular	50%	
D6112	Implant/abutment supported removable denture, partial, maxillary	50%	
D6113	Implant/abutment supported removable denture, partial, mandibular	50%	
D6114	Implant/abutment supported fixed denture, maxillary	50%	
D6115	Implant/abutment supported fixed denture, mandibular	50%	
D6116	Implant/abutment supported fixed denture for partial, maxillary	50%	
D6117	Implant/abutment supported fixed denture for partial, mandibular	50%	
D6120	Implant supported retainer, porcelain fused to titanium and titanium alloys	50%	
D6121	Implant supported retainer for metal FPD, predominantly base alloys	50%	
D6122	Implant supported retainer for metal FPD, noble alloys	50%	
D6123	Implant supported retainer for metal FPD, titanium and titanium alloys	50%	

CDT Code	Description	Member Responsibility	Limitation
	Implant Services (continued)		
D6190	Radiographic/surgical implant index, by report	50%	Only a Plan Benefit when exceptional medical conditions are met
D6191	Semi-precision abutment, placement	50%	
D6192	Semi-precision attachment, placement	50%	
D6194	Abutment supported retainer crown, FPD titanium, titanium and titanium alloys	50%	
D6195	Abutment supported retainer, porcelain fused to titanium and titanium alloys	50%	
D6199	Unspecified implant procedure, by report	50%	
	Fixed Prosthodontic Services		
D6205	Pontic, indirect resin based composite	not covered	
D6210	Pontic, cast high noble metal	not covered	
D6211	Pontic, cast predominantly base metal	50%	1 of (D2710-D2791, D6211-D6791) per tooth per 5 year period age 13 and over
D6212	Pontic, cast noble metal	not covered	
D6214	Pontic, titanium, and titanium alloys	not covered	
D6240	Pontic, porcelain fused to high noble metal	not covered	
D6241	Pontic, porcelain fused to predominantly base metal	50%	
D6242	Pontic, porcelain fused to noble metal	not covered	
D6243	Pontic, porcelain fused to titanium and titanium alloys	not covered	
D6245	Pontic, porcelain/ceramic	50%	
D6250	Pontic, resin with high noble metal	not covered	
D6251	Pontic, resin with predominantly base metal	50%	
D6252	Pontic, resin with noble metal	not covered	
D6545	Retainer, cast metal for resin bonded fixed prosthesis	not covered	
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis	not covered	
D6549	Resin retainer, for resin bonded fixed prosthesis	not covered	
D6608	Retainer onlay, porcelain/ceramic, two surfaces	not covered	
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	not covered	
D6610	Retainer onlay, cast high noble metal, two surfaces	not covered	
D6611	Retainer onlay, cast high noble metal, three or more surfaces	not covered	
D6612	Retainer onlay, cast base metal, two surfaces	not covered	
D6613	Retainer onlay, cast base metal, three or more surfaces	not covered	
D6614	Retainer onlay, cast noble metal, two surfaces	not covered	
D6615	Retainer onlay, cast noble metal three or more surfaces	not covered	
D6634	Retainer onlay, titanium	not covered	
D6710	Retainer crown, indirect resin based composite	not covered	
D6720	Retainer crown, resin with high noble metal	not covered	
D6721	Retainer crown, resin with predominantly base metal	50%	
D6722	Retainer crown, resin with noble metal	not covered	
D6740	Retainer crown, porcelain/ceramic	50%	
D6750	Retainer crown, porcelain fused to high noble metal	not covered	
D6751	Retainer crown, porcelain fused to predominantly base metal	50%	
D6752	Retainer crown, porcelain fused to noble metal	not covered	
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	not covered	
D6781	Retainer crown, ¾ cast predominantly base metal	50%	
D6782	Retainer crown, ¾ cast noble metal	not covered	
D6783	Retainer crown, ¾ porcelain/ceramic	50%	
D6784	Retainer crown ¾, titanium and titanium alloys	50%	
D6791	Retainer crown, full cast predominantly base metal	50%	
D6794	Retainer crown, titanium and titanium alloys	not covered	
D6930	Re-cement or re-bond fixed partial denture	50%	
D6980	Fixed partial denture repair, restorative material failure	50%	
D6999	Unspecified fixed prosthodontic procedure, by report	50%	
	Oral & Maxillofacial Services		
GUIDELINE: The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists			
D7111	Extraction, coronal remnants, primary tooth	50%	
D7140	Extraction, erupted tooth or exposed root	50%	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	50%	
D7220	Removal of impacted tooth, soft tissue	50%	
D7230	Removal of impacted tooth, partially bony	50%	
D7240	Removal of impacted tooth, completely bony	50%	
D7241	Removal impacted tooth, complete bony, complication	50%	
D7250	Removal of residual tooth roots (cutting procedure)	50%	
D7260	Oroantral fistula closure	50%	
D7261	Primary closure of a sinus perforation	50%	
D7270	Tooth reimplantation and/or stabilization, accident	50%	1 (D7270) per arch
D7280	Exposure of an unerupted tooth	50%	
D7283	Placement, device to facilitate eruption, impaction	50%	
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	50%	1 (D7285) per arch per date of service
D7286	Incisional biopsy of oral tissue, soft	50%	up to 3 (D7286) per date of service
D7287	Exfoliative cytological sample collection	not covered	
D7288	Brush biopsy, transepithelial sample collection	not covered	
D7290	Surgical repositioning of teeth	50%	1 (D7290) per arch, for active orthodontic treatment only
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	50%	1 (D7291) per arch, for active orthodontic treatment only
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	50%	
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	50%	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	50%	
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	50%	
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	50%	1 (D7340) per arch every 5 year period
D7350	Vestibuloplasty, ridge extension	50%	1 (D7350) per arch
D7410	Excision of benign lesion, up to 1.25 cm	50%	
D7411	Excision of benign lesion, greater than 1.25 cm	50%	

CDT Code	Description	Member Responsibility	Limitation
	Oral & Maxillofacial Services (continued)		
D7412	Excision of benign lesion, complicated	50%	
D7413	Excision of malignant lesion, up to 1.25 cm	50%	
D7414	Excision of malignant lesion, greater than 1.25 cm	50%	
D7415	Excision of malignant lesion, complicated	50%	
D7440	Excision of malignant tumor, up to 1.25 cm	50%	
D7441	Excision of malignant tumor, greater than 1.25 cm	50%	
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	50%	
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	50%	
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	50%	
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	50%	
D7465	Destruction of lesion(s) by physical or chemical method, by report	50%	
D7471	Removal of lateral exostosis, maxilla or mandible	50%	1 (D7471) per quadrant
D7472	Removal of torus palatinus	50%	1 (D7472) per lifetime
D7473	Removal of torus mandibularis	50%	1 (D7473) per quadrant
D7485	Reduction of osseous tuberosity	50%	1 (D7485) per quadrant
D7490	Radical resection of maxilla or mandible	50%	
D7510	Incision & drainage of abscess, intraoral soft tissue	50%	1 (D7510) per quadrant, same date of service
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	50%	1 (D7511) per quadrant, same date of service
D7520	Incision & drainage of abscess, extraoral soft tissue	50%	
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	50%	
D7530	Remove foreign body, mucosa, skin, tissue	50%	1 (D7530) per date of service
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	50%	1 (D7540) per date of service
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	50%	1 (D7550) per quadrant per date of service
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	50%	
D7610	Maxilla, open reduction (teeth immobilized, if present)	50%	
D7620	Maxilla, closed reduction (teeth immobilized, if present)	50%	
D7630	Mandible, open reduction (teeth immobilized, if present)	50%	
D7640	Mandible, closed reduction (teeth immobilized, if present)	50%	
D7650	Malar and/or zygomatic arch, open reduction	50%	
D7660	Malar and/or zygomatic arch, closed reduction	50%	
D7670	Alveolus, closed reduction, may include stabilization of teeth	50%	
D7671	Alveolus, open reduction, may include stabilization of teeth	50%	
D7680	Facial bones, complicated reduction with fixation, multiple surgical approaches	50%	
D7710	Maxilla, open reduction	50%	
D7720	Maxilla, closed reduction	50%	
D7730	Mandible, open reduction	50%	
D7740	Mandible, closed reduction	50%	
D7750	Malar and/or zygomatic arch, open reduction	50%	
D7760	Malar and/or zygomatic arch, closed reduction	50%	
D7770	Alveolus, open reduction stabilization of teeth	50%	
D7771	Alveolus, closed reduction stabilization of teeth	50%	
D7780	Facial bones, complicated reduction with fixation and multiple approaches	50%	
D7810	Open reduction of dislocation	50%	
D7820	Closed reduction of dislocation	50%	
D7830	Manipulation under anesthesia	50%	
D7840	Condylectomy	50%	
D7850	Surgical discectomy, with/without implant	50%	
D7852	Disc repair	50%	
D7854	Synovectomy	50%	
D7856	Myotomy	50%	
D7858	Joint reconstruction	50%	
D7860	Arthrotomy	50%	
D7865	Arthroplasty	50%	
D7870	Arthrocentesis	50%	
D7871	Non-arthroscopic lysis and lavage	50%	
D7872	Arthroscopy, diagnosis, with or without biopsy	50%	
D7873	Arthroscopy: lavage and lysis of adhesions	50%	
D7874	Arthroscopy: disc repositioning and stabilization	50%	
D7875	Arthroscopy: synovectomy	50%	
D7876	Arthroscopy: discectomy	50%	
D7877	Arthroscopy: debridement	50%	
D7880	Occlusal orthotic device, by report	50%	
D7881	Occlusal orthotic device adjustment	50%	
D7899	Unspecified TMD therapy, by report	50%	
D7910	Suture of recent small wounds up to 5 cm	50%	
D7911	Complicated suture, up to 5 cm	50%	
D7912	Complicated suture, greater than 5 cm	50%	
D7920	Skin graft (identify defect covered, location and type of graft)	50%	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot, stabilization, per site	50%	
D7940	Osteoplasty, for orthognathic deformities	50%	
D7941	Osteotomy, mandibular rami	50%	
D7943	Osteotomy, mandibular rami with bone graft; includes obtaining the graft	50%	
D7944	Osteotomy, segmented or subapical	50%	
D7945	Osteotomy, body of mandible	50%	
D7946	LeFort I (maxilla, total)	50%	
D7947	LeFort I (maxilla, segmented)	50%	
D7948	LeFort II or LeFort III, without bone graft	50%	
D7949	LeFort II or LeFort III, with bone graft	50%	
D7950	Osseous, osteoperiosteal, cartilage graft, mandible or maxilla, by report	50%	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	50%	

CDT Code	Description	Member Responsibility	Limitation
	Oral & Maxillofacial Services (continued)		
D7952	Sinus augmentation via a vertical approach	50%	
D7955	Repair of maxillofacial soft and/or hard tissue defect	50%	
D7961	Buccal / labial frenectomy (frenulectomy)	50%	1 (D7961) per arch per date of service
D7962	Lingual frenectomy (frenulectomy)	50%	1 (D7962) per arch per date of service
D7963	Frenuloplasty	50%	1 (D7963) per arch per date of service
D7970	Excision of hyperplastic tissue, per arch	50%	1 (D7970) per arch per date of service
D7971	Excision of pericoronal gingiva	50%	
D7972	Surgical reduction of fibrous tuberosity	50%	1 (D7972) per arch per date of service
D7979	Non – surgical sialolithotomy	50%	
D7980	Surgical sialolithotomy	50%	
D7981	Excision of salivary gland, by report	50%	
D7982	Sialodochoplasty	50%	
D7983	Closure of salivary fistula	50%	
D7990	Emergency tracheotomy	50%	
D7991	Coronoidectomy	50%	
D7995	Synthetic graft, mandible or facial bones, by report	50%	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	50%	1 (D7997) per arch per date of service
D7999	Unspecified oral surgery procedure, by report	50%	
	Orthodontic Services		
For Pediatric Dental, orthodontic treatment is a benefit of this Dental Plan ONLY when the patient's orthodontic needs meet medically necessary requirements as determined by a verified score of 26 or higher (or other qualify conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	50% per course of treatment, regardless of plan year, as long as member remains enrolled in the plan	age 13 and over
D8210	Removable appliance therapy		1 (D8210) per patient, age 6 through 12
D8220	Fixed appliance therapy		1 (D8220) per patient, age 6 through 12
D8660	Pre-orthodontic treatment examination to monitor growth and development		1 (D8660) every 3 months for a maximum of 6
D8670	Periodic orthodontic treatment visit		1 (D8670) per calendar quarter
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		1 (D8680) per arch for each authorized phase of orthodontic treatment
D8681	Removable orthodontic retainer adjustment		
D8696	Repair of orthodontic appliance, maxillary		1 of (D8696, D8697) per arch
D8697	Repair of orthodontic appliance, mandibular		
D8698	Re-cement or re-bond fixed retainer, maxillary		1 of (D8698, D8699) per arch per provider
D8699	Re-cement or re-bond fixed retainer, mandibular		
D8701	Repair of fixed retainer, includes reattachment, maxillary		
D8702	Repair of fixed retainer, includes reattachment, mandibular		
D8703	Replacement of lost or broken retainer, maxillary		1 of (D8703, D8704) per arch
D8704	Replacement of lost or broken retainer, mandibular		
D8999	Unspecified orthodontic procedure, by report		
	Adjunctive General Services		
D9120	Fixed partial denture sectioning	50%	
D9210	Local anesthesia not in conjunction, operative or surgical procedures	50%	1 (D9210) per date of service
D9211	Regional block anesthesia	50%	
D9212	Trigeminal division block anesthesia	50%	
D9215	Local anesthesia in conjunction with operative or surgical procedures	50%	
GUIDELINE: Deep Sedation and IV Conscious Sedation are covered benefits when it is documented local anesthesia is not possible, in such cases as a severe mental or physical handicap, extensive surgical procedures, an uncooperative child, an acute infection at the injection site, or a failure of a local anesthetic to control pain. Services covered when dispensed in a dental office by a practitioner acting within the scope of his/her licensure. Patient apprehension and/or nervousness are not of themselves sufficient justification.			
D9222	Deep sedation/general anesthesia, first 15 minute increment	50%	
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	50%	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	50%	
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	50%	
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	50%	
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	50%	
D9310	Consultation, other than requesting dentist	50%	
D9410	House/extended care facility call	50%	
D9420	Hospital or ambulatory surgical center call	50%	
D9430	Office visit, observation, regular hours, no other services	50%	1 (D9430) per date of service per provider
D9440	Office visit, after regularly scheduled hours	50%	1 (D9440) per date of service per provider
D9450	Case presentation, detailed & extensive treatment	not covered	
D9610	Therapeutic parenteral drug, single administration	50%	4 (D9610) per date of service
D9612	Therapeutic parenteral drugs, two or more administrations, different meds.	50%	4 (D9612) per date of service
D9910	Application of desensitizing medicament	50%	1 (D9910) per tooth every 12 months, for permanent teeth only
D9930	Treatment of complications, post surgical, unusual, by report	50%	1 (D9930) per date of service per provider
D9942	Repair and/or reline of occlusal guard	not covered	
D9943	Occlusal guard adjustment	not covered	
D9944	Occlusal guard, hard appliance, full arch	not covered	
D9945	Occlusal guard, soft appliance, full arch	not covered	
D9946	Occlusal guard, hard appliance, partial arch	not covered	
D9950	Occlusion analysis, mounted case	50%	1 (D9950) every 12 months, age 13 and over
D9951	Occlusal adjustment, limited	50%	1 (D9951) per quad every 12 months per provider, age 13 and over
D9952	Occlusal adjustment, complete	50%	1 (D9952) every 12 months, age 13 and over

LIBERTY Dental Plan of California, Inc.
Children's Dental HMO - Bright HealthCare IND Bronze 60 HDHP

General Exclusions:

1. Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.
2. Procedures, appliances, or restoration to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
3. Cosmetic dental care.
4. Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed.
5. Services that were provided without cost to the Member by State government or an agency thereof, or any municipality, county or other subdivisions.
6. Hospital charges of any kind are not covered by the Dental Plan. Refer to your Health Plan's Evidence of Coverage for benefit information.
7. Major surgery for fractures and dislocations.
8. Loss or theft of dentures or bridgework.
9. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.
10. Any service that is not specifically listed as a covered benefit unless service qualifies under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.
11. Malignancies.
12. Dispensing of drugs not normally supplied in a dental office.
13. Additional treatment costs incurred because a dental procedure is unable to be preformed in the dentists office due to the general health and physical limitations of the patient.
14. Services of a pedodontist/pediatric dentist, except when the Member is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is Medically Necessary, or his or her plan provider is a pedodontist/pediatric dentist.
15. Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonable should have known that an Emergency Care situation did not exist.

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Universal Care, Inc. DBA “Bright HealthCare”

Combined Evidence of Coverage and Disclosure Form for Individual and Family Plans

Effective: January 1, 2022

This combined evidence of coverage and disclosure form constitutes only a summary health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

For questions, please call Member Services at (844) 926-4524 or login at www.brighthealthcare.com. 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.

Universal Care, Inc.
5455 Garden Grove Blvd.
Suite 500
Westminster, CA 92683

Table of Contents

Section 1 - Title Page (Cover Page) 6
Information about Defined Terms 6
Entire Contract 6
How to Use this Document 6
Right to cancel or return this Agreement 6
Knox-KeenE Act 7
This is a Network-Only Plan 7
Section 2 - Contact Us 8
Nondiscrimination Notice and Assistance with Communication 8
Language Assistance and Alternate Formats 8
Section 3 - Definitions 12
Section 4 - Eligibility 24
Who is Eligible for Coverage 24
Eligible Subscribers 24
Eligible Dependents 24
When Coverage Begins 24
Open Enrollment Period 24
Special Enrollment Period 25
Delivery of Documents 27
Premiums/Prepayment Fees 27
If You Are Hospitalized When Your Coverage Begins 27
Extension of Benefits 27
Section 5 - How to Access Your Services and Obtain Approval of Benefits 28
Covered Health Services 28
This is a Network-Only Plan 28
Choose Your Physician (Choice of Physicians and Providers) 28
Choosing a Primary Care Physician 29
Referrals to Specialists 29
Standing Referral to Specialist 29
Provider Network 30
Completion of covered services 30
Continuity of Care 31
Access Plan 32
Designated Facilities and Other Providers 32
Receiving Non-Emergent Care From Non-Network Providers 32
Receiving Emergency Care From Network Providers or Network Facilities 32
Receiving Emergency Care From Non-Network Providers or Non-Network Facilities 32
Our Reimbursement Policies 33
Service Area 33
Medical Necessity 33
Medically Necessary Treatment of a Mental Health or Substance Use Disorder 34
Second Opinions 34
Pre-authorization 34
Care Management 35
Decide What Services You Should Receive 35
Show Your ID Card 35
Member Cost Sharing Requirements/other charges 36
Section 6 - Benefits/Coverage (What is Covered) 37
Benefit Determinations 37
Explanation of Covered Health Services 37
Listing of Covered Health Services 37
Acupuncture 37
Asthma Treatment Equipment and Supplies 38
Autism Spectrum Disorders (ASD) 38
Bariatric Surgery 39
Breast Cancer Treatment 39
Chemotherapy 39

Cleft Lip and Cleft Palate Treatment ... 40
Clinical Trials ... 40
Congenital Anomalies in Children and Newborns ... 41
Dental Anesthesia ... 41
Diabetes Education and Supplies ... 41
Dialysis Services ... 42
Durable Medical Equipment ... 42
Emergency Health Services ... 43
Emergency Transportation/Ambulance Services ... 43
Family Planning Services ... 43
Fertility Preservation Services ... 44
Gender Identity & Gender Transition Services ... 44
Genetic Testing ... 44
Habilitation Services ... 44
Hearing Services & Hearing Aids ... 45
Home Health Care Services ... 45
Hospice Services ... 45
Hospital and Free-Standing Facility Services ... 46
Imaging (CT/PET/MRI) ... 46
Infertility Treatment ... 46
Infusion Therapy ... 46
Laboratory Outpatient and Professional Services ... 46
Mastectomy and Lymph Node Dissections ... 46
Medical Supplies and Disposable Items ... 47
Nutritional Counseling ... 47
Oral Surgery ... 47
Orthotics and Special Footwear ... 48
Osteoporosis Services ... 48
Outpatient Surgery – Facility Services ... 48
Pediatric Dental Care ... 48
Pharmaceutical Products – Outpatient ... 54
Phenylketonuria (PKU) ... 54
Physician Fees for Surgical and Medical Services ... 55
Physician's Visits – Primary or Specialty Care to Treat an Injury or Illness ... 55
Pregnancy – Maternity Services ... 56
Prescription Drugs ... 56
Preventive Care/Screenings/Immunizations ... 62
Prosthetic Devices ... 64
Radiation ... 64
Reconstructive Procedures ... 65
Rehabilitation Services ... 65
Scopic Procedures – Outpatient Diagnostic and Therapeutic ... 66
Skilled Nursing ... 66
Sleep Studies ... 66
Transplant ... 67
Treatment for Temporomandibular Joint Disorders (TMJ) ... 67
Travel Expenses ... 67
Urgent Care Centers or Facilities ... 67
Vision Services ... 67
Vision Services for Children ... 68
Wigs ... 68
X-Ray, and Diagnostic Imaging ... 68
Section 7 - Limitations/Exclusions (What is Not Covered) ... 69
How We Use Headings in this Section ... 69
Benefit Limitations ... 69
Benefit Exclusions ... 69
Alternative Treatments ... 69
Chiropractic Care ... 69
Custodial or Domiciliary Care ... 69
Dental Care ... 70

Devices, Appliances ... 70
Directed Blood Donations ... 71
Employer or Governmental Responsibility ... 71
Experimental, Investigational, or Unproven Services ... 71
Foot Care ... 71
Genetic Testing ... 71
Hearing Aids ... 71
Infertility & Reproductive Services ... 71
Medical Supplies and Equipment ... 72
Nutritional Counseling ... 72
Other Services ... 72
Pediatric Dental Care - Exclusions ... 72
Personal Care, Comfort, or Convenience ... 73
Physical Appearance ... 74
Prescription Drug Exclusions ... 74
Prescription Drugs Limitations ... 76
Private Duty Nursing ... 76
Procedures and Treatments ... 76
Providers ... 76
Services Received Outside of Your Coverage Period ... 77
Services Rendered by a Non-Network Provider ... 77
Services that are not Medically Necessary ... 77
Transplantation Services ... 77
Travel ... 77
Types of Care ... 77
Vision Services ... 77
All Other Exclusions ... 77
Section 8 - Member Payment Responsibility ... 79
Your Responsibilities ... 79
Show Your ID Card ... 79
Pay Your Share ... 79
Pay the Cost of Excluded Services ... 79
Our Responsibilities ... 79
Pay for Our Portion of the Cost of Covered Health Services ... 79
Pay Network Providers ... 79
Offer Health Education Services to You ... 79
Section 9 - Claims Procedure (How to File a Claim) ... 80
If You Receive Covered Health Services from a Network Provider ... 80
Assignment of Benefits ... 80
Reimbursement Provisions ... 80
Required Claim Information ... 80
Claim Forms ... 80
Payment of Claims Upon Death ... 80
Finalization of Claims ... 80
Timely Filing ... 81
Time of Payment of Claims ... 81
Section 10 - General Provisions ... 82
Your Relationship with Us ... 82
Our Relationship with Providers ... 82
Your Relationship with Providers ... 82
Incentives to Providers ... 82
Incentives to You ... 82
Rebates and Other Payments ... 82
Inspection of Agreement ... 82
Interpretation of Benefits ... 83
Evaluation of New Technology ... 83
Administrative Services ... 83
Information and Records ... 83
Nondiscrimination ... 84
Change of Beneficiary ... 84

Examination and Autopsy 84
Integration of Medicare Benefits 84
Eligibility for Medicare 84
Non-Duplication of Medicare 84
Coordination of Benefits (COB) 85
Workers' Compensation 89
Subrogation and Reimbursement 90
Refund of Overpayments 91
Grace Period 91
Limitation of Legal Action 91
Liability of Subscriber to Pay Providers 91
Conformity with State Statutes 91
Fraudulent Acts Notice 91
Time Limit on Certain Defenses 92
Notices 92
Public Policy Participation Procedure 92
Other Information You Should Have 93
Member Rights and Responsibilities 93
You Have the Right to: 93
You Have the Responsibility to: 93
Section 11 - Termination/Nonrenewal/Continuation 95
Termination of Benefits 95
General Information about When Coverage Ends 95
Guaranteed Renewable 96
Reinstatement of Coverage 96
Continuation 96
Section 12 – Grievances and Appeals 97
Cultural and Linguistic Handling of grievances and appeals 97
What to Do if You Have a Question 97
What to Do if You Have a grievance or Complaint 97
Notice of Grievance Determination 98
Expedited Grievances 98
Expedited Grievance Review Process 98
Notice of Expedited Grievance Determination 99
Department of Managed Health Care Complaints 99
Independent Medical Review Process 99
Eligibility 99
Binding Arbitration 100
Section 13 - Information on Agreement and Rate Changes 101
Changes to this Agreement 101
Changes In Covered Persons 101
Changes to Premium Charge 101
Misstatement of Age 101
Address Changes 101
Renewal of Agreement 101
Other Coverage Offered by This Health Plan 101

Section 1 - Title Page (Cover Page)
Individual Agreement

This Combined Evidence of Coverage and Disclosure Form (also called the “Agreement”) includes important information that describes Your coverage. Your Agreement is a legal contract between the Subscriber and 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 Agreement is issued when We receive the application and in consideration of any and all required payment(s).

INFORMATION ABOUT DEFINED TERMS

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

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

ENTIRE CONTRACT

This Agreement includes Your:

- Evidence of Coverage and Health Service Agreement
- Summary of Benefits
- All endorsements, appendices, and all applications and forms for coverage.

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

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

A paper copy of this document will be provided to You upon request. Call Customer Service at the phone number listed in Section 2 to request a paper copy.

HOW TO USE THIS DOCUMENT

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

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

Make sure You understand how Your plan works. Many sections refer to other sections. You may not find all the information You need in one section. Keep this Agreement in a safe place so you can find and read it as needed. If You are an individual with special health care needs, please thoroughly read the sections that apply to You.

This Plan is only offered and issued in certain geographic areas within the state of California. If You no longer reside, live or work in the service area, You will no longer be able to enroll or remain enrolled with Bright HealthCare, even if You continue to reside in the state of California. Coverage will be terminated without regard to any health status-related factor.

RIGHT TO CANCEL OR RETURN THIS AGREEMENT

If for any reason you are not satisfied with the plan, you may return it to us with your identification card within thirty (30) 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 and You will be required to pay for any services during the thirty (30) day period. If no services were rendered, You are entitled to receive a full refund of any premium paid. This Contract is thereafter null and void.

KNOX-KEENE ACT

As a health care service plan, We are subject to the California Knox-Keene Health Care Service Plan Act of 1975, as amended, and the regulations promulgated thereunder ("Knox-Keene Act"). Any provision required in this Agreement by the Knox-Keene Act will bind Us whether or not that provision is provided in this Agreement.

We enter into this Agreement with You based upon the answers submitted by You and Your applicable Dependents on the signed Enrollment Application. In consideration for the payment of the premiums stated in this Agreement, We will provide services and benefits as described in this Agreement to You and Your enrolled Dependents.

You hereby expressly acknowledge that You understand this Agreement constitutes a contract solely between You and Bright HealthCare, an independent corporation operating under a license from the California Department of Managed Health Care (DMHC). You further acknowledge and agree that You have not entered into this Agreement based upon representations by any person other than Us, and that no person, entity or organization other than Us shall be held accountable or liable to You for any of Our obligations to You created under this Agreement. This paragraph shall not create any additional obligations whatsoever on Our part other than those obligations created under other provisions of this Agreement.

THIS IS A NETWORK-ONLY PLAN

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

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

You can review Our provider network online at www.brighthealthcare.com, or You can contact the *Customer Service* Department at the telephone number listed in *Section 2* of this *Agreement* and on Your ID card to obtain a copy of Our Provider Directory.

BRIGHT HEALTHCARE

Simeon Schindelman
Chief Executive Officer

Section 2 - Contact Us

Please contact Us for more information.

Questions About Your Benefits

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

On Our Website at:
www.brighthealthcare.com

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

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

NONDISCRIMINATION NOTICE AND ASSISTANCE WITH COMMUNICATION

Bright HealthCare does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. "Bright HealthCare" means Bright Health plans and their affiliates.

LANGUAGE ASSISTANCE AND ALTERNATE FORMATS

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

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

For help with these services, please call Customer Service at the number listed above or on Your ID Card.

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

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

After completing the Bright HealthCare grievance process or participating in the process for at least 30 days, you may file a grievance with the Department of Managed Healthcare (DMHC). You have the option to submit your IMR/Complaint form either online, by mail or by fax. For more information, please visit https://www.dmhc.ca.gov/FileaComplaint.aspx.

You can also file a complaint a based on race, color, national origin, age, disability or sex with the U.S Dept. of Health and Human Services, the Office of Civil Rights:

- Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
- Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
- Mail: U.S Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

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

bright HEALTH

Language Assistance and Alternate Formats
This information is available in other formats like large print. To ask for another format, please call (855) 827-4448.

English	ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call (855) 827-4448.
Spanish (US)	ATENCIÓN: Si no habla inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (855) 827-4448.
Chinese (S)	注意：如果您使用的语言并非英语，则可获得免费的语言协助服务请拨打电话 (855) 827-4448。
Arabic	انتباه: إذا كنت تتحدث لغة غير الإنجليزية، فخدمات المساعدة اللغوية متاحة من أجلك، دون تكلفة. بالرقم 827-4448 (855).
Bengali	মনোযোগ দিন: আপনি যদি ইংরাজী ব্যতীত অন্য কোনও ভাষায় কথা বলেন তাহলে ভাষা সহায়তা সংক্রান্ত পরিষেবাগুলি নিখরচায় আপনার জন্য উপলব্ধ। (855) 827-4448 নম্বরে কল করুন।
French	ATTENTION : Si vous parlez une autre langue que l'anglais, des services d'assistance linguistique sont mis gratuitement à votre disposition. Appelez (855) 827-4448.
German	ACHTUNG: Falls Sie eine andere Sprache als Englisch sprechen, steht Ihnen eine kostenfreie fremdsprachliche Unterstützung zur Verfügung. Wählen Sie die (855) 827-4448.
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε κάποια γλώσσα διαφορετική από τα Αγγλικά, παρέχονται δωρεάν υπηρεσίες γλωσσικής βοήθειας. Καλέστε το (855) 827-4448.
Italian	ATTENZIONE: se parla una lingua diversa dall'inglese, sono disponibili servizi di assistenza linguistica gratuiti. Chiami il numero (855) 827-4448.
Japanese	ご注意:英語以外の言語を話される場合は、無料の言語支援サービスをご利用いただけます。(855) 827-4448 までお電話ください。
Korean	주의: 영어가 아닌 다른 언어를 사용할 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 연락하십시오(855) 827-4448으로
Polish	UWAGA: Jeśli nie mówisz po angielsku, możesz skorzystać z darmowych usług tłumaczeniowych. Zadzwoń pod numer (855) 827-4448.
Portuguese	ATENÇÃO: Se falar um idioma que não o inglês, estão disponíveis serviços gratuitos de assistência de idioma para si. Contacte o número (855) 827-4448.
Russian	ВНИМАНИЕ: если вы не говорите на английском языке, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по телефону (855) 827-4448.
Tagalog	PAALALA: Kung nagsasalita ka ng isang wika bukod sa Ingles, magagamit mo ang mga serbisyong tulong sa wika nang walang bayad. Tumawag sa (855) 827-4448.
Urdu	دھیان دیں: اگر آپ انگریزی کے علاوہ کوئی دوسری زبان بولتے ہیں تو، آپ کے لئے زبان کی مدد کی خدمات مفت دستیاب ہیں۔ 827-4448 (855) پر کال کریں۔
Vietnamese	CHÚ Ý: Nếu bạn nói một thứ tiếng nào khác ngoài tiếng Anh, bạn sẽ được cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí. Gọi số (855) 827-4448.

Navajo	SHOOH: Biligáanaa bizaad doo dints'a'gó ata' hane' t'áájíikeh hóló. Bééésh bee hodíilni (855) 827-4448.
Amharic	ማሳሰቢያ: ከእንግሊዝኛ ውጪ የሆነ ቋንቋ የሚናገሩ ከሆነ ከክፍያ ነጻ የሆኑ የቋንቋ ድጋፍ አገልግሎቶችን ማግኘት ይችላሉ። በ (855) 827-4448 ይደውሉ።
Burmese	သင်သည် အင်္ဂလိပ်စကားမဟုတ်သော အခြားဘာသာစကားတစ်ခုအား ပြောဆိုသူဖြစ်ပါက ဘာသာစကားအခမဲ့ပံ့ပိုးသည့် ဝန်ဆောင်မှုအား သင်ရရှိနိုင်ပါသည်။ သင့် ID (သက်သေခံ) ကတ်ပြားပေါ်ရှိ အဖွဲ့ဝင်များဝန်ဆောင်မှုဌာန (855) 827-4448 သို့ ဖုန်းခေါ်ဆိုပါ။
Cherokee	ᎣᏫᏎᏍᏓᏝ: ᏦᎢ ᏥᏬᏂᏍᎩ ᏂᏬᏂᏏ ᏏᏃ ᎩᏢᏏ, ᏥᏬᏂᏝᎯᏍᏗ ᎠᏢᏍᏚᏢᏍᎩ ᎢᏗᏝᏛᏗᏝᎢᎢ, Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎩ ᎠᏎᏊᎢ, ᏂᎯ ᏒᎦᏛᏫᎢᏍᏓᏝᏗᎸᎢ. ᎾᏍᎩᏃ (855) 827-4448.
Cushite-Oromo	XIYYEEFFANNOO: Afaan Ingiliziin ala afaan kan biraa kan dubbattu yoo ta'e, tajaajilliwwan gargaarsa afaanii, kan tolaa, siif ni jiru. Bilbili (855) 827-4448.
French Creole	ATANSYON: Si ou pale yon lang ki pa Anglè, sèvis asistans lengistik la gratis, epi li disponib pou ou. Rele (855) 827-4448.
Gujarti	ધ્યાન આપો: જો તમે અંગ્રેજી સિવાયની અન્ય કોઈ ભાષા બોલો છો, તો તમારા માટે ભાષા સહાય સેવાઓ નિ:શુલ્ક ઉપલબ્ધ છે. (855) 827-4448 પર કૉલ કરો.
Hindi	ध्यान दें: यदि आप अंग्रेज़ी के अलावा कोई अन्य भाषा बोलते हैं, तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (855) 827-4448 पर कॉल करें।
Hmong	UA ZOO SAIB: Yog tias koj hais ib hom lus dhau ntawm lus As Kiv, muaj cov kev pab cuam txhais lus uas tsis xam nqi dab tsi rau koj tau siv. Thov hu rau (855) 827-4448.
Kru / Bassa	YI LE: I balè u mpot hop umpè èbes Ngissi, bot ba nhola ni kobol mahop bayé ha i nyuu yoñ, ngui nsaa wogui wo. Sebel Ndap Mahola i nyuu Mbon i nsinga i yé ntilgaga muuu i Kat yon i Mbon. Sébé ni njel singa ini nle (855) 827-4448.
Kurdish	ئاگاداری: ئەگەر بە زمانێکی تری جگە لە ئینگلیزی قسە دەکەیت، خزمەتگوزاریە زمانەوانیەکان بەخۆڕایی بۆ تۆ بەردەستن. پەیوەندی بە ژمارەی (855) 827-4448 بکەن.
Laotian	ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາອື່ນທີ່ບໍ່ແມ່ນພາສາອັງກິດ, ພວກເຮົາມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ (855) 827-4448.
Mon-Khmer	សម្គាល់៖ ប្រសិនបើអ្នកនិយាយភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស សេវាកម្មជំនួយភាសាដែលឥតគិតថ្លៃ គឺមានផ្តល់ជូនដល់អ្នក។ ទូរសព្ទ (855) 827-4448
Nepali	ध्यान दिनुहोस्: यदि तपाइँ अङ्ग्रेजी बाहेक अन्य भाषा बोल्नुनुहुन्छ भने तपाइँको लाग ि नि :शुल्क रूपमा भाषा सहायता सेवा उपलब्ध छ। (855) 827-4448 मा कल गर्नुहोस्।
Persian Farsi	توجه: اگر به زبانی غیر از انگلیسی صحبت می‌کنید، خدمات تسهیلات زبانی، رایگان در دسترس شما قرار می‌گیرند. با شماره (855) 827-4448 تماس بگیرید.
Serbo-Croatian	PAŽNJA: ako ne govorite engleski, nego neki drugi jezik, na raspolaganju su vam besplatne usluge jezične pomoći. Nazovite (855) 827-4448.
Syriac	ܙܘܗܪܐ: ܐܢ ܐܢܬ ܟܡܡܠܠܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬ ܠܡܫܬܡܫܝܬ ܒܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ (855) 827 4448
Thai	ข้อควรทราบ: หากคุณใช้ภาษาอื่นที่ไม่ใช่ภาษาอังกฤษ เรามีบริการความช่วยเหลือทางภาษา จัดให้แก่คุณโดยไม่คิดค่าใช้จ่ายใด ๆ ติดต่อหมายเลขโทรศัพท์ (855) 827-4448.

Turkish	DİKKAT: İngilizce haricinde bir dil konuşuyorsanız, dil yardım hizmetlerinden ücretsiz olarak faydalanabilirsiniz. (855) 827-4448 numaralı hattı arayın.
Ukrainian	УВАГА: якщо ви не розмовляєте англійською, то можете скористатися безкоштовними послугами мовної підтримки. Зателефонуйте за телефоном (855) 827-4448.
Yiddish	אַכטונג: אויב איר רעדן אַן אַנדער שפּראַך ווי ענגליש, שפּראַך הילף באַדינגען, פֿרײַ פֿון אָפּצאָל, זײַנען פֿאַראַנען פֿאַר אײַך (855) 827-4448 אָנקלינגט
Armenian	Ուշադրություն. Եթե դուք չեք խոսում անգլերեն, լեզվական աջակցության ծառայություններն անվճար են ձեզ համար: Զանգահարեք (855) 827-4448:
Punjabi	ਸਾਵਧਾਨ: ਜੇਕਰ ਤੁਸੀਂ ਅੰਗ੍ਰੇਜ਼ੀ ਤੋਂ ਇਲਾਵਾ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ। (855) 827-4448 ਤੇ ਕਾਲ ਕਰੋ।

Section 3 - Definitions

Advanced Premium Tax Credit – a federal tax credit for individuals that reduces the amount they pay for monthly premiums when they buy health insurance on the Exchange.

Adverse Determination means:

- A denial or delay of Pre-authorization for covered Benefits or a modification to the health care service(s) for which Pre-authorization was requested;
- A denial of a request for Benefits on the ground that the treatment or covered benefit is not Medically Necessary, appropriate, effective or efficient, or is not provided in or at the appropriate health care setting or level of care;
- A retroactive rescission or cancellation of coverage not attributable to failure to pay premiums;
- A denial of excluded Benefits, when evidence is provided that there is a reasonable medical basis that the contractual exclusion doesn't apply; or
- A denial of a request for Benefits on the grounds that the treatment or service is experimental or investigational.

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

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 Allowable 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 Allowable Amount. The Annual Deductible does not include any amount that exceeds the Allowable Amount.

Refer to the *Schedule of Benefits (Who Pays What) section of* this *Agreement* 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 Agreement. Your right to Benefits is subject to the terms, conditions, limitations, and exclusions of this Agreement, 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.

Bright HealthCare Member Hub – an online tool where Bright HealthCare enrollees can access information about their plan including benefits, provider network, prescription drug formularies, forms and claims details.

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

A Child will continue to be eligible until the end of the benefit year in which they reach age 26 if he or she continues to meet all other eligibility requirements. If the Dependent child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and is chiefly dependent upon the Subscriber for support, the Dependent can remain as a Dependent Child under the Agreement.

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

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

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

Completion of Covered Services –allows you to continue to receive services for specified medical and behavioral conditions for a defined period of time with doctors, hospitals, and Physicians who are Out-of-Network until the safe transfer of care to a Network Provider can be arranged.

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

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

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

Congenital Anomaly - a physical developmental defect that is 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 Surgery/Procedure - means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

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

- Unless otherwise specified, are provided for the purpose of diagnosing or treating a Sickness, Pregnancy, 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 *Agreement*.
- Services which are required to be covered by law.
- Not otherwise excluded in the *Limitations/Exclusions (What is Not Covered*) *section of this Agreement*.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under this Agreement. References to "You" and "Your" throughout this *Agreement* 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).
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Days' Supply Limit - This is the number of days of therapy You can receive for each prescription filled and re-filled under this benefit. 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 - the Subscriber's Spouse, Domestic Partner or Child who resides within the United States.

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

Designated Beneficiary Agreement – a reciprocal agreement which 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.

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 Qualified Health Plan**.**

Emergency - the sudden onset of what reasonably appears to be a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably result in any of the following:

- Placing the patient's health in serious jeopardy.
- Serious impairment to a bodily function.
- Serious dysfunction of any bodily organ or part.

- With respect to a pregnant woman who is in active labor:
  - There is inadequate time to effect safe transfer to another Hospital prior to delivery.
  - A transfer to may pose a threat to the health and safety of the patient or the unborn child.

Emergency Services or Emergency Services and Care - medical screening, examination, and evaluation by a Physician or surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Physician or surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility. Emergency Services and Care will not be covered if You did not require Emergency Services and Care and You reasonably should have known that an Emergency did not exist.

Emergency Services or Emergency Services and Care also means an additional screening, examination, and evaluation by a Physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition, within the capability of the facility. The care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general acute care hospital or an acute psychiatric hospital, as defined by state law. Emergency Services and Care will not be covered if You did not require Emergency Services and Care and You reasonably should have known that an Emergency did not exist.

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

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

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

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

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

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

Grievance - a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and includes a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative.

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 Care Providers – As related to the treatment of Mental Health and Substance Use Disorder (see definition below), a Health Care Provider means any of the following:

- A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
- An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.
- A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.
- An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.
- An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
- A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.
- A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.
- A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

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

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

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

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

Indian - means a person who is a member of an Indian tribe, as defined in Section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub.L. 93-638; 25 USC § 450b(d)),

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

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

- Phenylketonuria in Covered Persons who are less than 21 years of age.
- Maternal phenylketonuria in female Covered Persons of childbearing age who are less than 35 years of age.
- Maple syrup urine disease.
- Tyrosinemia.
- Homocystinuria.
- Histidinemia.
- Urea cycle disorders.
- Hyperlysinemia.
- Glutaric acidemias.
- Methylmalonic ademia.
- Proprionic academia;
- Immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins;
- Severe food protein induced enterocolitis syndrome;
- Eosinophilic disorders as evidenced by the results of a biopsy; and
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.

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

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

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

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

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

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

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

Maternal Mental Health – A mental health condition that impacts a woman during Pregnancy, peri or postpartum, or that arises during Pregnancy, in the peri or postpartum period, up to one (1) year after delivery.

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

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

- Obtained through a pharmacy.
- Prescribed for the treatment of Phenylketonuria (PKU), whether or not 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 our members. 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 setting, method, or manner, and with the supplies required by your medical condition, as determined to be necessary by qualified medical providers, unhindered by fiscal and administrative management.. 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.

Medically Necessary Treatment of a Mental Health or Substance Use Disorder: A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury,

condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
(i) In accordance with the generally accepted standards of mental health and substance use disorder care.
(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.
(iii) Not primarily for the economic benefit of the Plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

Should You wish to receive information regarding nonprofit professional associations Mental Health or Substance Use Disorder clinical review criteria, education program, and training materials, please contact Beacon Health Options of California:

By Mail: Beacon Health Options of California, P.O. Box 6065 Cypress, CA 90630-0065

By Fax: (877) 635-4602

By Phone: (800) 228-1286

By Secure Web Site: www.beaconhealthoptionsca.com

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.

Member - an Eligible Person who is properly enrolled under this Agreement.

Mental Health and Substance Use Disorder: A mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

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 Agreement*.

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

New Prescription Drug Product – a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA and ending on the earlier of the following dates:
- The date it is assigned to a tier by Our Pharmacy Therapeutics Committee.
- December 31st of the following calendar year.

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

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

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

Non-Network Pharmacy - A pharmacy that does not participate in the contract with Our Pharmacy Services Vendor. These pharmacies may fill Your prescriptions, but in most cases these services will not be covered by Us.

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

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

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

Refer to the *Schedule of Benefits (Who Pays What) section of this Agreement* 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 Agreement.

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

Physician - any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.
Note: *Other providers may include audiologist, certified respiratory care practitioner, chiropractor, clinical social worker, dentist, dietitian, dispensing optician, marriage, family and child counselor, mental health clinical nurse Specialist, nurse midwife, nurse practitioner, obstetrician/gynecologist, occupational therapist, optometrist, pharmacist, physical therapist, podiatrist, psychologist, psychiatric-mental health nurse, respiratory care practitioner, speech-language pathologist, or other provider who acts within the scope of his or her license. The fact that We describe a provider does not mean that Benefits for services from that provider are available to You under this Agreement.*

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

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

Pregnancy - includes all of the following:
- Prenatal care
- Postnatal care
- Childbirth
- Any Complications of Pregnancy

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

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

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

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

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

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

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.

Qualified Health Plan a health benefit plan that meet certain benefits and cost standards and has been certified by the Exchange through which the plan is offered.

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) - is a qualified small employer health reimbursement arrangement, also known as a small business HRA. It is a health coverage subsidy plan designed for employees of businesses with fewer than 50 full-time employees.

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

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

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

Responsible Adult – the person who enters into this Agreement on behalf of the child(ren) in the event there is no adult covered under this Agreement.

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

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

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

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

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

Sickness - Physical disease or physical illness.

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

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

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

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

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

Telehealth/Telemedicine - the delivery of medical services and diagnosis, consultation, or treatment using interactive audio, interactive video, or interactive data communication. Telehealth or Telemedicine visits are considered office visits and the cost-share for such services will not exceed the cost-share charged for the same services delivered in-person.

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

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

Usual, Customary and Reasonable Charge - is the median rate paid for similar 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.

Utilization Review - means either of the following:
(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to enrollees.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a health care service plan contract is covered as medically necessary for an enrollee.

Section 4 - Eligibility

We offer policies to Individuals and Families who are determined eligible by the Exchange for the purposes of enrollment in a Qualified Health Plan.

When an eligible person is enrolled, We refer to that person as a Covered Person, You or Your.

WHO IS ELIGIBLE FOR COVERAGE

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

- Reside in the Service Area (if You or an enrolled Dependent reside outside of the Service Area and incur health care services, You may be subject to higher Out-of-Pocket expenses);
- Not be entitled to or enrolled in Medicare Parts A/B and/or D on Your effective date of coverage with Us, per Medicare eligibility requirements. It is unlawful for Us to knowingly issue a Qualified Health Plan 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 Agreement to You.
- Meet the eligibility requirements established by Covered California, if enrolling for coverage through Covered California. Covered California's eligibility criteria can be found at www.CoveredCA.com.

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 Agreement*.
- Your Child(ren) as defined in the *Definitions section of this Agreement*.

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

Grandchildren of a Subscriber generally do not qualify as Dependents unless the grandparent is the grandchild's legal guardian. Coverage for children of a covered Dependent child or will end when the covered Dependent child is no longer eligible under this Agreement.

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

WHEN COVERAGE BEGINS

If you are a new Member with Bright HealthCare and have paid your first month's premium, your coverage will begin on the first day of the month following the date We receive Your premium. Your Effective Date will be listed on Your ID Card. No health services received prior to the Effective Date are covered.

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

OPEN ENROLLMENT PERIOD

Qualified persons are only permitted to enroll in a Qualified Health Plan (QHP), or to change QHPs, during an annual open enrollment period or a Special Enrollment Period for which the qualified person has experienced a qualifying event. Members may change QHPs during that time according to rules established by the Exchange. American Indians, and their Dependents, may move from one QHP to another QHP once per month at the same time.

The Effective Date is the date You meet all enrollment and Premium pre-payment requirements. It is the date You are accepted by Covered California and or Bright HealthCare.

The Open Enrollment period for coverage for the next calendar year begins on October 15 and ends January 31. Your Effective Date for coverage will depend on the date you apply for coverage:

- If You apply on or before December 15, Your Effective Date of Your coverage will be January 1.
- If You apply between December 16, and January 15, Your Effective Date of coverage will be February 1.

Off-Exchange Open Enrollment begins November 1 of the preceding calendar year and ends January 31 of the benefit year.

SPECIAL ENROLLMENT PERIOD

Persons who have a Qualifying Life Event as defined by state and federal law may be enrolled during a special enrollment period. 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.

Persons who experience a 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, through a Qualified Medical Child Support Order or a valid state or federal court order, or by entering into a Designated Beneficiary agreement.
- An individual is mandated to be covered as a dependent pursuant to a valid state or federal court order.
- A Subscriber loses a dependent or is no longer considered a dependent through divorce, legal separation, or dissolution of domestic partnership as defined by State law in the State in which the divorce, legal separation, or dissolution of domestic partnership occurs, or if the Subscriber, or his or her dependent, dies.
- An individual has been released from incarceration.
- An individual adequately demonstrates to the Department of Managed Health Care 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.
- An individual gains access to other creditable coverage as a result of a permanent change of residence.
- An individual was receiving services from a contracting provider under another health benefit plan, as defined by state law for one of the conditions described in the Completion of Covered Services provision of this Agreement, and the provider is no longer participating in the health benefit plan.
- An individual gains or maintains status of, or becomes the Dependent of an Indian. The individual and Dependent(s) may enroll in a QHP or change from one QHP to another one time per month together.
- The individual demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the department, with respect to health benefit plans offered outside the Exchange, that the individual did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because the individual was misinformed that the individual was covered under minimum essential coverage.
- The individual is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service.
- 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 health plan, producer, or Exchange.
- A qualified Individual is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if the qualified individual or his or her dependent has the option to renew such coverage. The date of the loss of coverage is the last day of the plan year.
- 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, who was not previously a citizen, a national, or a lawfully present individual, gains such status.
- An individual loses Medi-Cal coverage for Pregnancy-related services, or loses access to healthcare services through coverage provided to a pregnant woman's unborn child.
- An individual loses Medi-Cal coverage for medically needy. This Qualifying Life Event is limited to one occurrence per calendar year.
- An individual is a victim of domestic abuse or spousal abandonment or a dependent or unmarried victim within a household, is enrolled in minimum essential coverage, and sought to enroll in coverage separate from the perpetrator of the abuse or abandonment; or an individual is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim.
- A qualified individual or Subscriber, or his or her dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the qualified individual's or Subscriber's decision to purchase a QHP through the Exchange.

- A qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified; or the qualified individual is under 100 percent of the Federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence At the option of the Exchange.
- A qualified individual, or his or her dependent, who is enrolled in an eligible employer-sponsored plan is determined newly eligible for Advanced Premium Tax Credit because such individual is ineligible for qualifying coverage in an eligible employer-sponsored plan, including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage.
- A qualified individual, Subscriber, or dependent newly gains access to an individual coverage Health Reimbursement Arrangement (HRA) or is newly provided a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA). The triggering event is the first day on which coverage for the qualified individual, Subscriber, or dependent under the individual coverage HRA can take effect, or the first day on which coverage under the QSEHRA takes effect. An individual, Subscriber, or dependent will qualify for this special enrollment period regardless of whether they were previously offered or enrolled in an individual coverage HRA or previously provided a QSEHRA, so long as the individual, Subscriber, or dependent is not enrolled in the individual coverage HRA or covered by the QSEHRA on the day immediately prior to the triggering event.
- Any other event or exceptional circumstance occurs as set forth in rules from the DMHC 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.

Effective Dates of Coverage for Newborns

A newborn dependent child of the Subscriber is automatically covered for the first 31 days of life. A dependent newborn child must be enrolled 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, the Agreement will automatically convert to a family Agreement and the monthly premium amounts will be adjusted. The Subscriber will be required to pay the full premium amount for the newborn after the initial 31 days of coverage. Newborn premiums are not pro-rated.

Standard newborn charges will apply to the mother's deductible and maximum out-of-pocket amounts until the point of discharge. In the event the newborn incurs charges beyond the scope of standard newborn charges, charges will be applied to the newborn's deductible and maximum out-of-pocket.

Effective Dates of Coverage for Newly Adopted Children

Newly adopted children (including children newly placed for adoption), the effective date of coverage is the date on which the adoptive child's birth parent or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or spouse the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the subscriber's or spouse's right to control the health care of the child placed 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, the Agreement will automatically covert to a family Agreement and the monthly premium will be adjusted. The Subscriber is required to pay the full premium amount 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. Foster children are not eligible for enrollment as a Dependent child.

Effective Dates of Coverage for Other Dependents

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, i.e. a copy of the marriage certificate, Qualified Medical Support Order, etc. must be attached to the completed application.

Disabled Dependents

An enrolled Dependent child who reaches age 26 during a benefit year may remain enrolled as a Dependent until the end of that benefit year. The Dependent coverage shall end on the last day of the benefit year during which the Dependent child becomes ineligible. Foster Children and grandchildren are not covered. The attainment of age 26 shall not operate to terminate the coverage of a Dependent child while the child is and continues to be:

- Incapable of self-sustaining employment by reason of physically or mentally disabling injury, illness, or condition; and is
- Chiefly dependent upon the Subscriber for support and maintenance.

The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. Us or the Exchange must certify the Dependent's eligibility. We will notify the subscriber that the dependent child(s) coverage will terminate upon attainment of the limiting age unless the subscriber submits proof of the criteria described above to the plan within 60 days of the date of receipt of the notification. The Plan will send this notification to the subscriber at least 90 days prior to the date the child attains the limiting age. Upon receipt of a request by the subscriber for continued coverage of the child and proof of the criteria described in subparagraphs above, the Plan shall determine whether the child meets that criteria before the child attains the limiting age. If We fail to make the determination by that date, it shall continue coverage of the child pending its determination.

Dependents Not Enrolled When Newly Eligible

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.

DELIVERY OF DOCUMENTS

We will provide You with an Identification Card as well as a printed copy of Your Summary of Benefits and Coverage. You may request a copy of this Evidence of Coverage and other related benefits documents by contacting Customer Service, or you can visit Our website at https://member.brighthealthcare.com and find Your plan materials online.

PREMIUMS/PREPAYMENT FEES

We determine and establish the required monthly Premiums based on the age and region in which the Members reside. When You initiate changes to Your Agreement that result in a change to the Premiums, the changes to the Premiums will be reflected on the next billing statement. Premiums are due the 20th of the month for the next month's coverage. You may pay your premiums via automatic bank draft, or by credit or debit card through Our Member Hub.

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 health plan other than Bright HealthCare on the date you were admitted, Your prior health plan is responsible for payment of Covered Health Services for the Inpatient Stay through the date of discharge. Bright HealthCare will pay for related Covered Health Services in accordance with the terms of the Agreement, following discharge from the hospitalization. We will work with You to ensure a seamless transition of previously approved therapies or prescription medications.

If You are hospitalized on the effective date of Your coverage with Us and Your prior coverage was terminated due to an exit of the market or withdrawal of the plan in which You were enrolled, completion of Your care for Covered Health Services will be provided under this Policy.

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.

EXTENSION OF BENEFITS

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

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

COVERED HEALTH SERVICES

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*. All Covered Health Services are subject to the limitations and exclusions contained in the *Limitations/Exclusions (What is Not Covered) Section of this Agreement*.

THIS IS A NETWORK-ONLY PLAN

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

- You have a medical emergency;
- You are treated by a Non-Network Provider when you are receiving care at a Network Facility; or
- We authorize services out-of-network because the Medically Necessary services that You need are not available from a Participating Provider.
- When a Mental Health or Substance Use Disorder service is not available in network within geographic and timely access standards, We will arrange out-of-network services and follow-up services.

You can review Our provider network online at www.brighthealthcare.com, or You can contact the *Customer Service* Department at the telephone number listed in *Section 2* of this *Agreement* and on Your ID card to obtain a copy of Our Provider Directory.

CHOOSE YOUR PHYSICIAN (CHOICE OF PHYSICIANS AND PROVIDERS)

We arrange for health care providers to participate in Our Network. Network or Participating Providers are independent practitioners. They are not Our employees.

Participating Providers are listed on Our website at ***www.brighthealthcare.com*** or You can contact *Customer Service* at the telephone number listed in *Section 3* of this *Agreement* 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.

It is Your responsibility to select the health care professionals who deliver care to You from Our Network of Participating Providers. We encourage You to select a Primary Care Physician for Yourself and Your Dependents. If You do not select a Primary Care Physician within 60 days of Your effective date of coverage, We will assign a Primary Care Physician to You and notify You of the assignment. If Your choose to select a different Primary Care Provider, please notify Us.

Before obtaining services, You should always verify whether or not the Provider is a Participating Provider. A provider's status may change. You can verify the provider's status online at ***www.brighthealthcare.com*** or by calling *Customer Service* at the telephone number listed in Section 3 of this Agreement 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 Primary Care Physicians, eye care providers, mental health care providers, and pediatricians. You do not need approval from the plan or from any other person (including a primary care

provider) in order to obtain care from 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, or 3) following procedures for making referrals to other Participating Providers. For a list of participating providers, including health care professionals who specialize in eye care, mental health, and obstetrics or gynecology, visit Our website at www.brighthealthcare.com or call Our Customer Service line at the number listed in Section 3 of this Agreement and on Your ID card.

Liability of Subscriber to Pay Providers

In accordance with Our Provider agreements and applicable statutes, You will not be required to pay any In-Network Provider for amounts owed to that Provider by Us (other than your applicable Deductible, Copayment, and Coinsurance amounts), even in the unlikely event that We fail to pay the Provider.

CHOOSING A PRIMARY CARE PHYSICIAN

We encourage You to select a Primary Care Physician. You can search for a Primary Care Physician on our website at www.brighthealthcare.com, or You can call Customer Service at the number on Your ID Card or as listed in Section 3 of this Agreement if You would like assistance choosing a Primary Care Physician. A Primary Care Physician may be either a Physician who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by Us.

Certain obstetrical or gynecological health care professionals may also act as a Primary Care Physician. Please verify the OB/GYN is available as PCP on our website at www.brighthealthcare.com.

As noted above, it is Your responsibility to select the health care professionals who deliver care to You from Our Network of Participating Providers. We encourage You to select a Primary Care Physician for Yourself and Your Dependents. If You do not select a Primary Care Physician within 60 days of Your effective date of coverage, We will assign a Primary Care Physician to You and notify You of the assignment. If Your choose to select a different Primary Care Provider, please notify Us.

REFERRALS TO SPECIALISTS

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

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

STANDING REFERRAL TO SPECIALIST

Your PCP may request a standing Referral to a Specialist Provider for you when the following conditions apply:

- You are a covered Member of a Bright HealthCare Individual Plan;
- You have a disease or condition that is life threatening, degenerative, chronic or disabling;
- You have HIV/AIDs;
- Your Primary Care Physician in conjunction with a Network Specialist determines that Your care requires another Provider's expertise;
- Your PCP determines that Your disease or condition will require ongoing medical care for an extended period of time;
- The standing Referral is made by Your Primary Care Physician to a Network Specialist who will be responsible for providing and coordinating Your specialty care; and
- The Network Specialist is authorized by Us to provide the services under the standing Referral.

We may limit the number of visits and time period for which You may receive a standing Referral. A standing Referral may be effective for up to 12 months and may be renewed and re-renewed by Your Primary Care

Physician. If You receive a standing Referral or any other Referral from Your Primary Care Physician, that Referral remains in effect even if the Primary Care Physician ceases to be a Participating Provider under the Plan. If the treating Specialist leaves Our network or You cease to be a covered Member, the standing Referral expires.

Standing Referrals to Non-Network Providers will be allowed when the care is not available from a Participating Network Provider. In a case where We do not have a Network Provider or specialist within Our network to provide services for a covered benefit, We will authorize a standing Referral to see a Non-Network Provider. You will not be denied necessary medical care or charged additional expenses because use of a Non-Network Provider is required. If this occurs, You will not be responsible for any payments beyond the Copayment, Deductible and Coinsurance amounts that You would have paid had You received services from a Network Provider.

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*** or You may obtain a copy by calling *Customer Service* at the telephone number listed in Section 2 of this Agreement 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 may be required to choose another Network Provider to get Network Benefits. See the Completion of Covered Services section below to request services from a terminated or Non-Participating Provider.

COMPLETION OF COVERED SERVICES

The Completion of Covered Services provision of this Agreement allows you to continue to receive services for acute and/or serious chronic conditions for a defined period of time with doctors, hospitals, and Providers who are Out-of-Network until the safe transfer of care to a Network Provider can be arranged.

Completion of Covered Services is available for the following conditions:

- Acute Conditions. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- Serious Chronic Conditions. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Us in consultation with You and Your terminated or Non-Participating Provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed twelve (12) months from the contract termination date or 12 months from the effective date of coverage for a newly covered Member.
- A Pregnancy. A Pregnancy is the three (3) trimesters of Pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the Pregnancy.
- Maternal mental health. Completion of covered services for the maternal mental health condition shall not exceed twelve (12) months from the diagnosis or from the end of Pregnancy, whichever occurs later.
- A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a new Member.
- The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services under this paragraph shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered Member.

- Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered Member.

For information on how to apply for Completion of Covered Services, contact Bright HealthCare Plan Customer Service at (844) 926-4524.

CONTINUITY OF CARE

Continuity of Care allows you to receive services at Network coverage levels for specified medical and behavioral conditions for a defined period of time when your Network doctor, hospital, or Provider leaves our Network.

If you are under the care of a Network Provider for one of the medical conditions below, and the Network Provider caring for you is terminated from the Network by us, we can arrange, at your request and subject to the Provider's agreement, for continuation of Covered Health Services rendered by the terminated Provider for the time periods shown below. Co-payments, Deductibles or other cost sharing components will be the same as you would have paid for a Provider currently contracting with us.

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

- An Acute Condition – An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. Treatment by the terminated Provider may continue for the duration of the acute condition.
- A Serious Chronic Condition - A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Treatment by the terminated Provider for a serious chronic condition may continue for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by Us in consultation with the Member and the terminated Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the date the Provider's contract terminated.
- Maternal mental health - Covered services for the maternal mental health condition shall not exceed twelve (12) months from the contract termination date, or twelve (12) months from the diagnosis or from the end of Pregnancy, whichever occurs later.
- A Pregnancy. A Pregnancy is the three (3) trimesters of Pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the Pregnancy.
- A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of a terminal illness, which may exceed twelve (12) months from the Provider's contract termination date.
- The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
- Performance of a surgery or other procedure that We have authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within one-hundred eighty (180) days of the Provider's contract termination date.

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

Services that You may receive from a terminated Provider under the Continuity of Care provision will be limited to the condition(s) for which the Continuity of Care has been approved.

For information on how to apply for Continuity of Care, contact Bright HealthCare Plan Customer Service at (844) 926-4524.

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 Agreement and on Your ID card. The

provider's Network status is subject to change, so always confirm the provider's Network status with the provider at the time services are received.

ACCESS PLAN

We have prepared and maintain a Network Access Plan that describes how We monitor the Network of providers to ensure that You have access to care. The Network access plan is maintained at Our offices. Please contact *Customer Service* at the number listed in *Section 2 of this Agreement* and on Your ID card for the location office nearest You.

DESIGNATED FACILITIES AND OTHER PROVIDERS

If You have a medical condition that We believe needs special services, We may direct You to a Designated Facility or designated Physician chosen by Us. If You require certain complex Covered Health Services for which expertise is limited, We may direct You to a Network facility or provider that is outside Your Service Area. If You are required to travel to obtain such Covered Health Services from a Designated Facility or designated Physician, We will reimburse certain travel expenses as described under the Travel Expenses provision located Section 6 of this Agreement.

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

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

RECEIVING NON-EMERGENT CARE FROM NON-NETWORK PROVIDERS

There are specific situations when this Plan will cover non-emergent services from Non-Network Providers.

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

Non-emergent services from Non-Network Providers are covered by the Plan when We pre-authorize Medically Necessary care to a Non-Network Provider because the care is not available from a Participating Network Provider. In a case where We do not have a Network Provider or specialist within Our network to provide services for a covered benefit, We will issue Pre-authorization to see a Non-Network Provider. You will not be denied necessary medical care or charged additional expenses because use of a Non-Network Provider is required. If this occurs, You will not be responsible for any payments beyond the Copayment, Deductible and Coinsurance amounts that You would have paid had You received services from a Network Provider.

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

RECEIVING EMERGENCY CARE FROM NETWORK PROVIDERS OR NETWORK FACILITIES

When receiving Medically Necessary emergency care from a Participating or In-Network facility, You will be responsible for Your Annual Deductible, Copayment or Coinsurance amounts as indicated in Your Schedule of Benefits.

RECEIVING EMERGENCY CARE FROM NON-NETWORK PROVIDERS OR NON-NETWORK FACILITIES

When receiving emergency care from a Non-Network Provider in a Non-Network facility, or from a Non-Network air ambulance service provider, payment from the Plan, unless otherwise permitted by law, will be the greater of :

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

You will not be responsible for any payments beyond the Copayment, Deductible and Coinsurance amounts that You would have paid had You received services from a Network Provider. Cost-sharing amounts paid by You will count toward Your Out-of-Pocket Maximum and Deductible in the same manner as if You utilized a Network Provider, Facility, or air ambulance service provider.

OUR REIMBURSEMENT POLICIES

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

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

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

Network Providers are contractually obligated to follow Our reimbursement policies and may not balance bill for denials based on Our reimbursement policies.

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

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.

Please see Our provider directory on Our website at ***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 Agreement and on Your ID card for assistance.

MEDICAL NECESSITY

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

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

- it is a health intervention for the purpose of treating a medical condition
- it is the most appropriate supply or level of service, considering potential benefits and harms to the patient
- it is performed in the setting, method, or manner, and with the supplies required by your medical condition, as determined to be necessary by qualified medical providers, unhindered by fiscal and administrative management.
- 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
  1. by scientific evidence
  2. by professional standards
  3. by expert opinion; and
  4. by consideration of cost-effectiveness compared to alternative interventions, including no intervention.

MEDICALLY NECESSARY TREATMENT OF A MENTAL HEALTH OR SUBSTANCE USE DISORDER

We define Medically Necessary Treatment of a Mental Health or Substance Use Disorder as a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.
(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.
(iii) Not primarily for the economic benefit of the Plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

SECOND OPINIONS

If you wish to seek a second opinion about treatment that has been recommended to You, We encourage You to do so. Reasons to seek a second opinion may include, but are not limited to, the following:

- If You question the reasonableness or necessity of recommended surgical procedures.
- If You question a diagnosis or treatment plan for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and You request an additional diagnosis.
- If the treatment plan in progress is not improving the medical condition within an appropriate period of time given the diagnosis and the treatment plan, and You request a second opinion regarding the diagnosis or continuance of the treatment.
- If You have attempted to follow the treatment plan or consulted with the initial provider concerning serious concerns about the diagnosis or treatment plan.

You may ask your Physician to refer you to a Participating Provider for the second opinion.

You will be responsible for the costs of applicable copayments or coinsurance for the second opinion according to the benefits of Your plan.

If there is no appropriately qualified Participating Provider within Our network to provide the second opinion, We will authorize the second opinion to be performed by an appropriately qualified professional outside of Our network, at In-Network costs.

If the Provider from whom You receive a second opinion recommends additional care or treatment, Pre-Authorization and Referral requirements may apply to the services recommended.

PRE-AUTHORIZATION

Pre-authorization is the process of reviewing a request for health care services for Medical Necessity and network affiliation prior to You receiving those services.

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, he or she may not balance bill You.

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:

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

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

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.

We must make Our decision within 5 business days of receiving the Prior Authorization request and Physician's statement. You can request an expedited exception if you or your Physician believes that your health could be seriously harmed by waiting 5 calendar days for a decision. If your request to expedite is granted, we must give you a decision no later than seventy-two (72) hours after we get the supporting statement from your Physician. We will make Our determination for post-service Pre Authorization requests within thirty (30) calendar days.

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.

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.

SHOW YOUR ID CARD

You should show Your identification (ID) card every time You request health services. If You do not show Your ID card, the provider will fail to bill the correct entity for the services delivered, and any resulting delay may mean that You may be unable to collect any Benefits otherwise owed to You. The billing address used is based on the plan under which Your coverage is issued; therefore, it is important that You verify that Your provider has the correct billing information on file for Your plan.

MEMBER COST SHARING REQUIREMENTS/OTHER CHARGES

Cost-sharing amounts include deductibles, coinsurance, copayments and any other expense required of a Member. Depending on the type of care You receive, and where you receive care, Your cost-sharing amounts will differ. Refer to the *Schedule of Benefits (Who Pays What) section of this Agreement* to determine what Your cost-sharing requirements are.

Annual Deductible is the amount You must pay towards any Allowable Amounts for Covered Health Services incurred in a calendar year, before We will begin paying for Benefits. Deductible amounts accumulate towards Your Out-of-Pocket Maximum.

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

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

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

All Deductible, Copayment and Coinsurance payments for In-Network Covered Health Services will apply to the Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been met for a Covered Person, the Covered Person will have no further obligation to pay Deductible, Copayment or Coinsurance amounts for Covered Health Services received from a participating Bright HealthCare Provider for the remainder of the Calendar Year.

For policies with two or more people, each person's Individual Out-of-Pocket Maximum applies to the Family Out-of-Pocket Maximum. Once a Covered Person has met his or her Out-of-Pocket Maximum, the Covered Person will have no further obligation to pay charges for In-Network Covered Health Services for the remainder of the Plan Year. Once two (2) or more people's combined Out-of-Pocket expenses reach the Family Out-of-Pocket Maximum, Covered Persons under the Family policy will have no further obligation to pay charges for 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 *Agreement* 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 Agreement. When making a benefit determination, we will have discretionary authority to interpret the terms and provisions of the Agreement. This discretionary authority should not be construed to limit the legal action that may be taken by an insured or beneficiary in accordance with the Limitation of Legal Action provision of the Agreement 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, Pregnancy or associated symptoms, unless otherwise specified
- Services which are Medically Necessary for the purpose of treating Mental Health and/or Substance Use Disorders
- Covered Health Services are received while this Agreement is in effect
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in the *Termination/Nonrenewal/Continuation* S*ection of this Agreement*
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in this Agreement.

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

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

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

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

LISTING OF COVERED HEALTH SERVICES

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

Acupuncture

Covered Health Services include the therapeutic application of acupuncture treatment provided to treat nausea, or as part of a comprehensive pain management program for the treatment of chronic pain.

Asthma Treatment Equipment and Supplies
Covered Health Services under this plan includes asthma treatment equipment and supplies such as inhaler spacers, nebulizers (including face masks and tubing), and peak flow meters when Medically Necessary for the management and treatment of asthma, including education to enable the Member to properly use the device(s).

Autism Spectrum Disorders (ASD)
Covered Health Services under this section include coverage for the assessment, diagnosis, and treatment of Autism Spectrum Disorder. Services are subject to the same cost-sharing provisions as other medical or prescription drug covered by the plan.

Behavioral Health Treatment means professional services and treatment programs, included Applied Behavioral Analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorder.

Treatment must be provided by a licensed Physician or developed by a licensed psychologist and under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:
- A Qualified Autism Service Provider.
- A Qualified Autism Service Professional supervised by the qualified Autism Service Provider.
- A Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional.

The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with applicable State law that imposes requirements on the provision of Behavioral Health Treatment.

In order to serve members who are eligible to receive treatment for Autism Spectrum Disorder, the Qualified Autism Service Provider is required to provide a treatment plan that:
- Describes the patient's behavioral health impairments or developmental challenges that are to be treated.
- Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Autism Spectrum Disorder.
- Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to Us upon request.

"Autism Spectrum Disorder" includes the following, in accordance with the DSM IV, and as amended in the most recent edition of the DSM:
- Autistic Disorder
- Rett's Disorder
- Childhood Disintegrative Disorder
- Asperger's Disorder
- Pervasive Developmental Disorder Not Otherwise Specified (including Atypical Autism).

"Qualified Autism Service Provider" means either of the following:
- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Autism Spectrum Disorder, provided the services are within the experience and competence of the person who is nationally certified; or
- A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor,

speech-language pathologist, or audiologist pursuant to State law, who designs, supervises, or provides treatment for Autism Spectrum Disorder, provided the services are within the experience and competence of the licensee.

"Qualified Autism Service Professional" means an individual who meets all of the following criteria:

- Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider;
- Is supervised by a Qualified Autism Service Provider;
- Provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider;
- Is a behavioral service provider who meets the education and experience qualifications described in State law for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program;
- Has training and experience in providing services for Autism Spectrum Disorder pursuant to State law; and
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the Autism treatment plan.

"Qualified Autism Service Paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:

- Is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice;
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider;
- Meets the education and training qualifications as defined by State law;
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers; and
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the Autism treatment plan.

Any treatment for Autism Spectrum Disorder must be deemed Medically Necessary.

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

Breast Cancer Treatment
This Plan will provides coverage for services related to Breast Cancer including screening and diagnosis of breast cancer consistent with generally accepted medical practice and scientific evidence. Treatment for breast cancer includes coverage for prosthetic devices or Reconstructive Surgery to restore and achieve symmetry for the patient following a mastectomy.

Please see Mastectomy and Lymph Node Dissections for information about those services.

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

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 Agreement*.

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

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

Clinical Trials
The following definitions are used throughout this section:

"Approved 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. Additionally, the Approved Clinical Trial must meet the following criteria:

(A) The study is approved or funded 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 federal Centers for Medicare & Medicaid Services.
  (v) A 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) One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
    (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 United States Food and Drug Administration.

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

"Life-threatening disease or condition" means a disease or condition from which the likelihood of death is probable, unless the course of the disease or condition is interrupted.

"Qualified enrollee" means an enrollee who meets both of the following conditions:

(A) The enrollee is eligible to participate in an Approved Clinical Trial, according to the clinical trial protocol, for the treatment of cancer or another life-threatening disease or condition.

(B) Either of the following applies:
  (i) The referring health care professional is a participating provider and has concluded that the enrollee's participation in the clinical trial would be appropriate because the enrollee meets the conditions of subparagraph (A).
  (ii) The enrollee provides medical and scientific information establishing that the enrollee's participation in the clinical trial would be appropriate because the enrollee meets the conditions of subparagraph (A).

"Routine patient care costs" refers to drugs, items, devices and services provided consistent with coverage under

the contract for an enrollee who is not enrolled in a clinical trial, including the following:
(A) Drugs, items, devices, and services typically covered absent a clinical trial.
(B) Drugs, items, devices, and services required solely for the provision of an investigational drug, item, device, or service.
(C) Drugs, items, devices, and services required for the clinically appropriate monitoring of the investigational drug, item, device, or service.
(D) Drugs, items, devices, and services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.
(E) Drugs, items, devices, and services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis and treatment of complications.

"Routine patient care costs" does not include the following:
- The investigational drug, item, device, or service itself.
- Drugs, items, devices and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the enrollee.
- Drugs, items, devices, and services specifically excluded from coverage in the contract, except for drugs, items, devices, and services required to be covered pursuant to this section or other applicable law.
- Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

The coverage is subject to all terms and conditions of this Agreement. Annual Deductible and Out-of-Pocket Maximums shall apply if the clinical trial is not offered or available through a Participating Provider.

We may restrict coverage to an Approved Clinical Trial in California, unless the clinical trial is not offered or available through a Participating Provider in California.

We shall not:
- Deny a qualified enrollee's participation in an Approved Clinical Trial;
- Deny, limit or impose additional conditions on the coverage of routine patient care costs for items and services furnished in connection with a qualified enrollee's participation in an Approved Clinical Trial;
- Discriminate against an enrollee based on the qualified enrollee's participation in an Approved Clinical Trial.

Congenital Anomalies in Children and Newborns
Covered Health Services under this section include necessary treatment and care of medically diagnosed congenital defects and birth abnormalities, including Medically Necessary outpatient rehabilitation services.

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

Dental Anesthesia
Covered Health Services under this section include general anesthesia and associated facility charges for dental procedures rendered in a dentist's office or a hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered.

Coverage shall apply only to general anesthesia and associated facility charges for the following Members, and only for:
- Members who are under seven (7) years of age;
- Members who are developmentally disabled, regardless of age;
- Members whose health is compromised and for whom general anesthesia is Medically Necessary, regardless of age.

Diabetes Education and Supplies
Covered Health Services under this section include the following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as Medically Necessary, even if the items are available without a prescription:

- Blood glucose monitors and blood glucose testing strips.
- Blood glucose monitors designed to assist the visually impaired.
- Insulin pumps and all related necessary supplies.
- Ketone urine testing strips.
- Lancets and lancet puncture devices.
- Pen delivery systems for the administration of insulin.
- Podiatric devices to prevent or treat diabetes-related complications.
- Insulin syringes.
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.
- Insulin.
- Prescriptive medications for the treatment of diabetes.
- Glucagon.

Coverage under this plan also includes:
- 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.
- Diabetic shoes
- Insulin pumps. One Insulin pump every three (3) years will be covered at 100% of the Allowable Amount and is not subject to the Annual Deductible, Copayment, or Coinsurance. Applicable cost-sharing as shown in the Durable Medical Equipment section of the Schedule of Benefits applies to additional insulin pumps. Any supplies used in conjunction with the insulin pump will be subject to the *Durable Medical Equipment* provision.

Dialysis Services
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 education is required for a disease in which patient self-management is an important component of treatment.

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 Agreement*.

Durable Medical Equipment
Benefits under this section include standard Durable Medical Equipment or supplies that adequately meet Your medical needs and that are provided to You by a Physician and are:
- For use in the patient's home.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

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. Continuous rental equipment must be Pre-authorized.

Examples of Durable Medical Equipment include:
- Equipment to assist mobility, such as a standard wheelchair

- A standard Hospital-type bed
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors, and masks).
- Delivery pumps for tube feedings
- 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 is available for repairs and replacement. This does not include coverage for repair and replacement damage due to misuse, malicious breakage or gross neglect.

DME Benefits do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

Durable Medical Equipment supplies are authorized in accordance with what is considered reasonable for a thirty (30) day period. When quantities exceed Our requirements for what is reasonable for a given period of time, We may require Pre-Authorization for the quantities beyond what is considered reasonable. We will continue to provide the Medically Necessary Durable Medical Equipment within the guidelines of Our Continuity of Care policy as outlined in Section 5 - How to Access Your Services and Obtain Approval of Benefits.

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 will 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.

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

Emergency Transportation/Ambulance Services
This Plan will cover Medically Necessary emergency transportation via licensed ground, air or water ambulance, or ambulance transport services provided through the “911” emergency response system to the nearest Hospital where Emergency Health Services can be performed.

The Plan will also cover *Non-Emergency* ambulance transportation and psychiatric transport van services when provided by a licensed transport service and when:
- We or a Participating Provider determine the patient’s condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide; and
- The use of other means of transportation would endanger the patient’s health; and
- When the vehicle transports the Member to or from covered services.

Non-emergent ambulance transportation requires Pre-Authorization.

Family Planning Services
Family Planning Services covered under the Plan include:
- Medical history;

- Physical examinations;
- Related laboratory tests;
- Information and counseling on contraception;
- Medically appropriate voluntary sterilization;
- Abortions;
- FDA-approved prescription contraceptive methods including implanted/injected contraceptives, and over-the-counter medications and follow-up services. These services and medications are covered at no cost to You. Please reference Section 6 - Benefits/Coverage (What is Covered), Preventive Care/Screenings/Immunizations, for additional information.

Fertility Preservation Services
Fertility preservation services are covered for members undergoing treatment or receiving Covered Health Services that may directly or indirectly cause iatrogenic infertility. Under these circumstances, Fertility Preservation Service are a Covered Health Service and do not fall under the scope of Infertility Services as described later in this section.

Gender Identity & Gender Transition Services
Covered Health Services under this section include Medically Necessary medical, behavioral health and surgical services in relation to gender dysphoria, gender identity, gender transition and confirmation. Covered services may include supportive mental health counseling and treatment of any additional co-morbid mental health conditions, appropriate hormonal treatment interventions, orchiectomy, oophorectomy and hysterectomy, as well as genital reconstructive surgery where those interventions and treatments comply with all other provisions of the Plan, such as Pre-authorization. Failure to obtain the Pre-authorization prior to receiving care may result in services not being covered.

Appropriate screening services covered under the plan will continue to be a Covered Health Service subject to all other terms and provisions of the Plan regardless of gender assignment including but not limited to mammograms.

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

Genetic Testing
Covered Health Services under this section includes prenatal diagnosis of fetal genetic disorders including tests for specific genetic disorders for which genetic counseling is available.

Habilitation Services
Habilitation 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.

<u>Outpatient Habilitation Services</u>
Covered Health Services under this section include the following outpatient Habilitation Services:
- Physical therapy;
- Occupational therapy;
- Speech therapy;and
- Other services for people with disabilities

<u>Inpatient Habilitation Services</u>
Covered Health Services under this section include services and supplies provided during an Inpatient Stay in an Inpatient Habilitation/Rehabilitation Facility.

Coverage is available for:
- Services, supplies, and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for anesthesiologists, consulting Physicians, pathologists, and radiologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services provision of the *Benefits/Coverages (What is Covered) section of this Agreement*.)

- Medically Necessary Supplies
- Skilled care, skilled teaching 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 require clinical training in order to be delivered safely and effectively.
- Other services for people with disabilities.

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 You will receive skilled care services that are not primarily Custodial Care.

Limits for rehabilitative and habilitative services shall not be combined.

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

Home Health Care Services
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 schedule, and when skilled care is required.

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 care services are limited to 100 visits per calendar year.

Hospice Services
Covered Health Services under this section include hospice care that is recommended by a Physician and that is designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of an Member who is experiencing the last phases of life due to the existence of a terminal disease, to provide supportive care to the primary care giver and the family of the hospice patient, and which meets all of the following criteria:
- Considers the Member and the Member's family, in addition to the Member, as the unit of care.
- Utilizes an interdisciplinary team to assess the physical, medical, psychological, social and spiritual needs of the Member and the Member's family.
- Requires the interdisciplinary team to develop an overall plan of care and to provide coordinated care which emphasizes supportive services, including, but not limited to, home care, pain control, and short-term inpatient services. Short-term inpatient services are intended to ensure both continuity of care and appropriateness of services for those Members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.
- Provides for physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.
- Provides for the palliative medical treatment of pain and other symptoms associated with a terminal disease, but does not provide for efforts to cure the disease.
- Provides for bereavement services following the Member's death to assist the family to cope with social and emotional needs associated with the death of the Member.
- Actively utilizes volunteers in the delivery of hospice services.

- To the extent appropriate based on the medical needs of the Member, provides services in the Member's home or primary place of residence.

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, Pregnancy, 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 2 bed room rate, unless a private room is Medically Necessary.
- Care in Special Care Units such as Intensive Care, Cardiac Care, Neonatal Care, when Medically Necessary
- Operating rooms, delivery rooms and special treatment rooms
- Supplies and services such as laboratory, cardiology, pathology and radiology received while in the Hospital
- Drugs, medicines and oxygen provided during your stay
- Blood, blood plasma, blood derivatives and blood factors, blood transfusions including blood processing and storage costs.

Imaging (CT/PET/MRI)
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.

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

Infusion Therapy
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 education is required for a disease in which patient self-management is an important component of treatment.

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 Agreement*.

Laboratory Outpatient and Professional Services
Covered Health Services under this section include laboratory 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.

Laboratory services for preventive care are described under *Preventive Care Services provision*.

Mastectomy and Lymph Node Dissections
Members who are getting benefits for a mastectomy or for Follow-up Care for a mastectomy and who choose breast reconstruction, will also get coverage for:

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

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 such as pouches, face plates, belts, irrigation sleeves and bags, and skin barriers.
- Incontinence supplies for hospice patients such as disposable incontinence underpads, and adult incontinence garments.
- Catheter Supplies
- Tubing and connectors for delivery pumps
- Burn garments
- Supplies related to insulin pumps

Medical Supplies are covered in accordance with what is considered to be reasonable for a thirty (30) day period. When quantities exceed Our requirements for what is reasonable for a given period of time, We may require Pre-Authorization for the quantities beyond what is considered reasonable. We will continue to provide the Medically Necessary supplies within the guidelines of Our Continuity of Care policy as outlined in Section 5 - How to Access Your Services and Obtain Approval of Benefits.

Mental Health and Substance Use Disorders
We will cover Medically Necessary Treatment of a Mental Health or Substance Use Disorders (see definition above) including Covered Benefits 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.

Inpatient Substance Use Disorder services may include, but are not limited to:
- Detoxification for the medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education and counseling
- Transitional residential recover services or chemical dependency treatment

Additionally, We cover outpatient services for the treatment of Mental Health or Substance Use Disorder including but not limited to:
- Mental health evaluations and assessment, including maternal mental health
- Diagnosis
- Treatment planning
- Referral services
- Medication management
- Short-term individual, family, and group therapeutic services (including intensive outpatient therapy)
- Crisis intervention
- Day treatment programs
- Intensive outpatient programs
- Substance use and chemical dependency evaluations and assessment
- Medical treatment for withdrawal symptoms

Benefits include treatment of Mental Health or Substance Use Disorder 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.

Nutritional Counseling
We cover Medically Necessary nutritional counseling when necessary to treat a medical condition.

Oral Surgery
This plan covers benefits for certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, ectodermal dysplasia, or other craniofacial anomalies associated with cleft palate;
- Orthognathic (jawbone) surgery for a medical condition or injury which improves function of the joint or bone that is Medically Necessary to gain functional capacity of the joint or bone
- Treatment of acute traumatic injury or Medically Necessary treatment of Temporomandibular Joint Disorder, dislocation tumors, jaw alignment, or cancer.
- Oral / surgical correction of Accidental Injuries.
- Treatment of lesions, removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Orthotics and Special Footwear
When Medically Necessary, benefits are available for:
- Orthotics (braces, boots, splints) for foot disfigurements resulting from bone deformity, motor impairment, paralysis, or amputation. This includes but is not limited to, disfigurement caused by cerebral palsy, arthritis, polio, spina bifida, diabetes, accident, injury, or developmental disability, and
- Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent or treat diabetes-related complications.

Covered Services include determining if You need the device, initial purchase, fitting, adjustment, and repair.

Osteoporosis Services
This Plan will provide coverage for services related to the diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed Medically Necessary.

Outpatient Surgery – Facility Services
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 and Pregnancy are considered 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 Agreement*.)

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

We will cover pediatric dental benefits when Medically Necessary. Additional requests, beyond the stated frequency limitations shall be considered under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) when documentation supports medical necessity.

The decision as to what dental care treatment is best for You is solely between You and Your dentist.

<u>Diagnostic & Preventive Services</u>
This plan covers Preventive Dental Care services that help prevent oral disease from occurring. Such services include:
- Oral evaluations
    - Periodic Oral Evaluation is covered up to one (1) time per six (6) months, per provider.
    - Comprehensive Oral Evaluation is limited to one (1) per patient for initial evaluation.
    - Limited and problem focused oral evaluations are covered up to one per patient per provider.
    - Re-evaluations imited problem-focused are covered up to six (6) in a three (3) month period, no more than twelve (12) in twelve (12) months

    - Comprehensive periodontal evaluation covered as a comprehensive oral evaluation
- Radiographs (x-rays)
    - Bitewing, single (1) radiographic images covered once (1) per date of service; Bitewings, two (2) radiographic images once (1) every six (6) months per provider; Bitewings, three (3) radiographic images must be billed as Single (1) Bitewing and Bitewings, two (2) radiographic images; Bitewings four (4) radiographic images covered once (1) per six (6) months per provider for members age ten (10) and over; Vertical bitewings covered as Bitewings Four (4) radiographic images
    - Single intraoral periapical radiographic images – Up to twenty (20) are covered in any twelve (12) month period, by the same provider
    - Intraoral, occlusal radiographic images – Up to two (2) per six (6) months per provider
    - Extra-oral 2D projection radiographic image, stationary radiation source – One (1) per date of service
    - Extra-oral posterior dental radiographic image – One (1) per date of service
    - Full mouth radiographic images – Covered up to one (1) in any thirty-six (36) month period, per provider
    - Panoramic radiographic image – Covered up to one (1) in any thirty-six (36) month period, per provider
    - Sialography
    - Temporomandibular joint arthrogram, including injection – Covered for the survey of trauma or pathology for a maximum of three (3) per date of service
    - Tomographic survey – Covered twice (2) in a twelve (12) month period, per provider
    - 2D Cephalometric radiographic image – Covered twice (2) in a twelve (12) month period, per provider
    - 2D oral/facial photographic image, intra-orally/extra-orally – Covered four (4) per date of service
- Pulp vitality tests
- Diagnostic casts – Covered for the evaluation of orthodontic services only, once (1) per provider, for permanent dentition
- Caries risk assessment and documentation
- Other oral pathology procedures, by report
- Unspecified diagnostic procedure, by report
- Dental cleaning (prophylaxis) – Covered once (1) in a six (6) month period. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth. Scaling in the presence of moderate or severe inflammation included with dental cleaning limitation.
- Fluoride treatment - Topical application of fluoride or fluoride varnish covered once (1) in a six (6) month period
- Preventive dental education and oral hygiene instruction
- Dental sealant treatments, including preventive resin restoration –
- Covered once (1) in a thirty-six (36) month period, for 1st, 2nd, and 3rd molars only
- Caries preventive medicament application - Covered once (1) per tooth in a six (6) month period
- Space maintainers– One (1) per quad per arch under age 18
    - Re-cement or re-bond space maintainer – One per quad or per arch every twelve (12) months, under age 18
    - Removal of fixed space maintainer

<u>Basic Restorative Services</u>

- Amalgam and resin-based composite restorations (fillings) – Primary teeth, one (1) per surface per tooth every twelve (12) months; Permanent teeth, one (1) per surface per tooth every thirty-six (36) months.
- Resin-based composite crown, anterior – Primary teeth, one (1) per tooth every twelve (12) months; Permanent teeth, one (1) per tooth every thirty-six (36) months.
- Restorations are limited by the following conditions:
    - When Medically Necessary, when carious activity or fractures have extended through the dentinoenamel junction and when the tooth demonstrates a reasonable longevity
    - If the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries (decay), any other restoration, such as a crown, is considered an Optional Treatment
    - Replacement of a restoration is covered only if it is defective, as shown by conditions as recurrent decay or fracture, and replacement is Medically Necessary
- Recementation of crowns, inlays, and onlays
    - Re-cement or re-bond inlay, onlay, veneer or partial coverage – Covered one (1) per tooth every 12 months, per provider
    - Re-cement or re-bond indirectly fabricated/prefabricated post & core
    - Re-cement or re-bond crown limited to after twelve (12) months of initial placement

    - Reattachment of tooth fragment, incisal edge or cusp
- Prefabricated crowns – Covered once (1) in a twelve (12) month period for primary teeth, covered once (1) in a 36 month period for permanent teeth
- Prefabricated resin crown or stainless steel crown with resin window – Covered once (1) per tooth in a twelve (12) month period for primary teeth, covered once (1) in a thirty- six (36) month period for permanent teeth
- Core buildup, including any pins when required
- Each additional indirectly fabricated post, same tooth and each additional prefabricated post, same tooth
- Pin retention, post and core and prefabricated post and core in addition to crown - Limited to one (1) per tooth
- Crown repair necessitated by restorative material failure – Covered after twelve (12) months of initial crown placement with same provider
- Protective restoration - covered one (1) per tooth every six (6) months, per provider
- Interim therapeutic restoration, primary dentition
- Restorative foundation for an indirect restoration
- Post removal
- Additional procedure to construct new crown, existing partial denture frame
- Unspecified restorative procedure, by report

Major Restorative Services
- Single Crowns – Included but not limited to; resin-based composite and ¾ resin-based composite (indirect), Resin with predominately base metal, porcelain/ceramic, porcelain fused to base metal crowns. – Covered once (1) per tooth per five (5) year period, for members ages 13 and over.

Endodontic Services
- Direct and indirect pulp capping
- Therapeutic pulpotomy (excluding final restoration) – Covered once (1) per primary tooth
- Pulpal debridement, partial pulpotomy and pulpal therapy – Covered once (1) per tooth
- Treatment of root canal obstruction and Internal root repair
- Apexification/recalcification, initial visit and interim medication replacement – Covered once (1) per tooth
- Retrograde filling, per root
- Surgical procedure for isolation of tooth with rubber dam
- Root canal therapy – Initial treatment is covered once (1) per tooth, retreatment is limited to once (1) per tooth after twelve (12) months of initial treatment
- Apicoectomy
- Surgical repair of root resorption
- Unspecified endodontic procedure, by report

Periodontal Services
- Periodontal scaling, root planing and subgingival curettage – Covered up to one (1) per site/quadrant in any twenty-four (24) month period for ages thirteen (13) and over.
- Scaling in the presence of moderate or severe inflammation – Covered once (1) in a six (6) month period, included with dental cleaning limitation
- Gingivectomy or gingivoplasty, or Osseous surgery – One (1) per site/quad every thirty-six (36) months, age 13 and over
- Clinical crown lengthening, hard tissue
- Full mouth debridement to enable comprehensive evaluation and diagnosis
- Biologic materials to aid in soft and osseous tissue regeneration
- Localized delivery of antimicrobial agent/per tooth
- Periodontal maintenance – One (1) every three (3) months.
- Unscheduled dressing change (other than treating dentist or staff) – Covered one (1) per patient per provider, age thirteen (13) and over
- Unspecified periodontal procedure, by report

Oral Surgery and Maxillofacial Services
- Oral Surgery Services - These services include post-operative care such as examinations, suture removal and treatment of complications
- Simple Tooth extractions

- Extractions, including Surgical extractions - Removal of impacted teeth is covered only when evidence of pathology exists
- Removal of residual tooth roots
- Exposure of an unerupted tooth
- Placement, device to facilitate eruption, impaction
- Alveoloplasty
- Biopsy of oral tissues - incisional biopsy of oral tissue, hard (bone, tooth) limited to one (1) per arch per date of service; incisional biopsy of oral tissue, soft limited to three (3) per date of service
- Excision and removal of lesions, cysts and neoplasms
- Destruction of lesions by physical or chemical method, by report
- Incision and drainage of abscesses - intraoral soft tissue limited to one (1) per quadrant, same date of service; and intraoral soft tissue, complicated limited to one (1) per quadrant, same date of service
- Removal of lateral exostosis – limited to one (1) per quadrant
- Treatment of palatal torus and mandibular torus - removal of torus mandibularis, and reduction of osseous tuberosity is limited to one (1) per quadrant; removal of torus palatinus is limited to one (1) per lifetime
- Radical resection of maxilla or mandible
- Arthroscopy
- Sialolithotomy
- Sialodochoplasty
- Emergency tracheotomy
- Oroantral fistula closure
- Primary closure of a sinus perforation
- Maxilla and Mandible open and closed reduction
- Stabilization of teeth
- Tooth reimplantation and/or stabilization, accident – Covered one (1) per arch
- Surgical repositioning of teeth – Covered one (1) per arch, for active orthodontic treatment only
- Transseptal fiberotomy – Covered one (1) per arch, for active orthodontic treatment only
- Vestibuloplasty, ridge extension – Covered one (1) per arch , 2nd epithelialization limited to one (1) per arch per five (5) Year period
- Removal of foreign bodies – limited to one (1) per date of service
- Maxillary sinusotomy for removal of tooth fragment or foreign body
- Treatment for upper or lower jaw fractures or dislocations
- Treatment for Temporomandibular Joint Disorder
- Occlusal orthotic device, by report; and other device adjustment
- Sutures
- Skin grafts
- Osteoplasty and Osteotomy
- Sinus augmentation and repair
- Partial ostectomy/sequestrectomy for removal of non-vital bone - Covered one (1) per quadrant per date of service
- Facial reconstruction, including LeFort I, Le Fort II, LeFort III, and Osseous Cartilage Graft
- Frenulectomy – Buccal/labial Covered one (1) per arch per date of service; and lingual Covered one (1) per arch per date of service
- Frenuloplasty - Covered one (1) per arch per date of service
- Excision of hyperplastic tissue, per arch - Covered one (1) per arch per date of service
- Excision of pericoronal gingiva
- Surgical reduction of fibrous tuberosity – Covered once (1) per quadrant per date of service
- Excision of salivary gland, by report
- Sialolithotomy – Surgical and Non-surgical
- Synthetic graft, mandible or facial bones, by report
- Coronoidectomy
- Closure of salivary fistula
- Appliance removal (not by dentist who placed appliance), includes removal of archbar – Covered one (1) per arch per date of service
- Unspecified oral surgery procedure, by report

Prosthodontic Services

Benefits include the following:

- Fixed bridges – Bridges made of cast, porcelain cused to metal, or resin with predominantly base metal covered once, per tooth every five (5) year period age 13+ gold are covered as follows:
  - When it is necessary to replace a single missing permanent anterior (front) tooth one side of an arch and the patient's condition allows for supporting (abutment) teeth on each side of the missing tooth.
  - When a patient has a medical condition that prevents the use of a removable partial denture. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered an Optional Treatment
  - Fixed bridges are not covered in the presence of untreated moderate to severe periodontal disease or when a proposed supporting tooth/teeth has a poor outcome.
  - Fixed bridges used to replace missing posterior (back) teeth are considered Optional Treatment when the abutment teeth are sound and would be crowned only for the purpose of supporting a pontic (fake tooth)
  - Fixed bridges are considered Optional Treatment when provided in connection with a partial denture on the same arch
  - Replacement of a fixed bridge is covered only if the existing bridge cannot be made satisfactory by repair
  - A cantilever bridge (supported on one end only) is not covered for the replacement of a missing posterior tooth.
- We will cover up to five (5) units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction and is an Optional Treatment.
- Fixed partial denture repair
- Recementation of bridges
- Unspecified fixed prosthodontic procedure, by report
- Dentures – Including full/partial maxillary, full/partial mandibular, teeth, clasps, stress breakers and prosthetics. Dentures are covered as follows:
  - Complete and partial dentures limited to one (1) per arch every five (5) Year period
  - Immediate complete and partial dentures limited to one (1) per arch per patient. Stayplates only a covered when used as an anterior space maintainer for children
  - Adjustments limited to two (2) per arch every twelve (12) months, one (1) per arch per date of service per provider
  - Repair broken complete denture base, limited to once (1) per arch per date of service per provider, limited to twice (2) per arch every twelve (12) months per provider
  - Replacement of missing or broken teeth, complete denture limited to four (4) per arch per date of service per provider, limited to twice (2) every twelve (12) months per provider
  - Repairs for resin denture base, and cast framework limited to one (1) per arch per date of service per provider, limited to twice (2) every twelve (12) months per provider
  - Repair or replace broken clasp, per tooth limited to three (3) per arch per date of service per provider, limited to twice (2) per arch every twelve (12) months per provider
  - Replace broken teeth, per tooth limited to four (4) per arch per date of service per provider, limited to two (2) per arch per twelve (12) months per provider
  - Add tooth to existing partial denture, limited to three (3) per arch per date of service per provider, one (1) per tooth
  - Add clasp to existing partial denture, limited to three (3) per date of service per provider, twice (2) per arch every twelve (12) months per provider
  - Complete or Partial denture Relines limited to one (1) every twelve (12) months, covered six (6) months after initial placement of appliance if extractions were required, twelve (12) months after initial placement of appliance if extractions were not required
  - Tissue conditioning limited to two (2) per arch every thirty-six (36) months
  - Precision attachment, by report
  - Unspecified removable prosthodontic procedure, by report
- Maxillofacial Prosthetic Services
  - Maxillofacial prosthetic services are for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.
  - All maxillofacial prosthetic procedures require written documentation for payment or authorization.
  - Obturator prosthesis modification limited to two (2) every twelve (12) months
  - Feeding aid limited to under age eighteen (18)

- Modifications for Palatal lift and speech aid prostheses limited to two (2) every twelve (12) months

Implant Services
We only cover implants and implant related services when exceptional medical conditions are present. Implants are not covered for replacement of teeth due to decay, periodontal disease or to restore occlusion (bite) due to tooth loss or due to normal aging of the patient.

Implants Exception Medical Conditions:
Exception medical conditions that may be considered for implants services are as follows:
- Cancer of the oral cavity requiring surgery and/or radiation leading to destruction of alveolar bone, where the missing osseous structures are unable to support removable denture.
- Severe deterioration of the gums on the upper and/or lower arches that cannot be corrected with oral surgery procedures, and the patient is unable to function with a removable denture.
- Skeletal deformities that prevents the use of removable dentures (such as arthrogryposis, ectodermal dysplasia, partial anodontia and cleidocranial dysplasia).
- Traumatic destruction of jaw, face, or head where the remaining structures are unable to support a removable denture.
- Special Needs patients may qualify for implant services. Special Needs Patients are defined as those patients who have a physical, behavioral, developmental, or emotional condition that prohibits them from adequately responding to a provider's attempts to perform an examination.

Orthodontic Services
Orthodontic treatment is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. To be considered Medically Necessary orthodontic care, determination will be made by the Provider in accordance with the guidelines established by the Plan; and the service must be preauthorized by the Plan. Medical Necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, or facial trauma resulting in functional difficulties. We will authorize the service if it is necessary to restore the form and function of the oral cavity, such as through a result of injury or dysfunction resulting from congenital deformities. Medically Necessary orthodontic care can be beneficial to generally prevent disease and promote oral health. To be considered Medically Necessary orthodontic care, at least one of the following must be present:
- There is spacing between adjacent teeth which interferes with the biting function;
- There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when You bite;
- Positioning of the jaws or teeth impair chewing or biting function;
- On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- Based on a comparable assessment of the above bullets, there is an overall orthodontic problem that interferes with the biting function.
- Any of the following automatic qualifying conditions:
  - Cleft Palate deformity
  - Cranio-facial Anomaly
  - Deep Impinging Overbite
  - Crossbite of Individual Anterior Teeth
  - Severe Traumatic Deviation
  - Overjet/Mandibular Protrusion
  - Conditions creating a minimum score of 26 points on the Handicapping Labio- Lingual Deviation (HLD)

You or Your orthodontist should send Your treatment plan to Us to find out if it will be covered under this Agreement.

Benefits include, but are not limited to, the following:
- Comprehensive (complete) Treatment – Full treatment includes all radiographs, diagnostic casts/models, appliances and visits; limited to members age thirteen (13) and over
- Minor Treatment – Treatment to control harmful habits
- Removable Appliance Therapy – An appliance that is removable and not cemented or bonded to the teeth; covered once (1) per patient, ages six (6) through twelve (12)

- Fixed Appliance Therapy – A component that is cemented or bonded to the teeth; covered once (1) per patient, ages six (6) through twelve (12)
- Orthodontic retention (removal of appliances, construction and placement of retainer); covered once (1) per arch for each authorized phase of orthodontic treatment Replacement of lost or broken retainer appliances; covered once (1) per arch
- Removable orthodontic retainer adjustment and repair of fixed retainers
- Repair of orthodontic appliance – covered once (1) per arch
- Re-cement or re-bond fixed retainer – covered once (1) per arch per provider
- Treatment that is already in progress with appliances placed before You were covered by this Agreement will be covered on a pro-rated basis.
- Please refer to Your Benefit Schedule to see a full description of the Covered Services.

Other Services

- Adjunctive General Services – Covered for the following:
  - Emergency treatment, palliative treatment – limited to one (1) per date of service
  - Anesthesia and local anesthetics
  - Oral, IV conscious sedatives and nitrous oxide when dispensed at a dental office by a provider acting within the scope of their licensure
  - Local anesthesia not in conjunction, operative or surgical procedures limited to one (1) per date of service
  - Consultations – This benefit includes Specialist consultations
  - Therapeutic parenteral Drug single and multiple administration, different medicaments - limited to four (4) per date of service
  - Fixed partial denture sectioning
  - House/extended care Facility call
  - Hospital or Ambulatory Surgical Center call
  - Office Visit, observation, regular hours, no other services - limited to one (1) per date of service per provider
  - Office Visit, after regularly scheduled hours - limited to one (1) per date of service per provider
  - Teledentistry – real-time encounter and information stored and forward to dentist for subsequent review
  - Application of desensitizing medicament – limited to (one) 1 per tooth every twelve (12) months, for permanent teeth only
  - Treatment of complications, post-surgical unusual, by report – limited to one (1) per date of service per provider
  - Dental case management, patients with special health care needs
  - Occlusion analysis - limited to one (1) per twelve (12) months, age thirteen (13) and over
  - Occlusal adjustment, limited – covered one (1) per quadrant every twelve (12) months per provider, age thirteen (13) and over o Occlusal adjustment, complete – covered one (1) per twelve (12) months, age thirteen (13) and over
  - Unspecified adjunctive procedure, by report

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.

Phenylketonuria (PKU)
Benefits for the testing and treatment of phenylketonuria (PKU) are paid on the same basis as any other medical condition. Cost-sharing amounts will apply in accordance with Your Schedule of Benefits and the type of Provider, Facility in which You receive care, or under Your Durable Medical Equipment benefit if You receive medical supplies. Coverage for treatment of PKU shall include formulas and special food products that are part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Participating Provider who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a

consequence of PKU.

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. “Formula” means an enteral product or products for use at home. The formula must be prescribed by a Physician or nurse practitioner, or ordered by a registered dietician upon Referral by a health care Provider authorized to prescribe dietary treatments, and is Medically Necessary for the treatment of PKU.

Formulas and special food products used in the treatment of PKU that are obtained from a Pharmacy are covered under the Prescription Drug benefit of this Plan. Formulas and special food products that are not obtained from a Pharmacy are covered under this benefit.

“Special food product” means a food product that is all of the following:

- Prescribed by a Physician or nurse practitioner for the treatment of PKU, and
- Consistent with the recommendations and best practices of qualified Health Professionals with expertise in the treatment and care of PKU, and
- Used in place of normal food products, such as grocery store foods, used by the general population.
  - It does not include a food that is natural low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

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 Visits – Primary or Specialty Care to Treat an Injury or Illness.*

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

Physician’s Visits – Primary or Specialty Care to Treat an Injury or Illness
Covered Health Services under this section include primary or specialty care services provided by a Physician for the diagnosis and treatment of a Sickness or Injury. Coverage is provided under this section regardless of whether the Physician's office is freestanding, provided as a home visit, located in a clinic, located in a Hospital, or provided as Telemedicine/Telehealth if available.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when education is required for a disease in which patient self-management is an important component of treatment.

Telehealth/Telemedicine
Telehealth or Telemedicine visits are considered office visits and the cost-share for such services will not exceed the cost-share charged for the same services delivered in-person. Telehealth or Telemedicine services will be subject to the same Deductible and Out-of-Pocket provisions as in-person visits.

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 Coinsurance will apply to Clinic Fees.

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 Agreement.*

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, maternal mental health 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 coverage for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy and procedures for the prenatal diagnosis of fetal genetic disorders including tests for specific genetic disorders for which genetic counseling is available. These are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We will pay Benefits for a stand-alone birthing center or for an inpatient Hospital stay of at least:
- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

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

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

This Plan covers participation in the Expanded Alpha Feto Protein Program, a statewide prenatal testing program administered by California's Department of Public Health.

Timely Post-Delivery Care
If the mother and attending Provider agree to discharge a mother and her newborn child from the inpatient setting before the expiration of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, We shall provide coverage for timely postdelivery care in a manner that meets the health care needs of the mother and her newborn child and that provides for the appropriate monitoring of the conditions of the mother and child. Care shall be provided to a mother and her newborn child by a registered nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health in the home, a provider's office, a hospital, a birthing center, an intermediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic, or another setting determined appropriate under federal regulations.

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 for prescribing a length of stay not in excess of 48 hours (or 96 hours)

Maternal Mental Health
We cover a Maternal Mental Health program that includes education of Pregnancy - Maternity Services benefits (see above). You may contact Us and elect to enroll in the Maternal Mental Program. The Maternal Mental Health Program will provide the following:
- Education of maternity benefits, including mental health benefits.
- An initial medical and mental health assessment
- The opportunity to collaborate with a nurse to establish an optional care plan including outreach cadence
- A post-delivery communication to assist with post-partum medical service planning, as well as an additional mental health assessment.

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

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

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

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

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

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

We have a program for specialty medications through a Specialty Pharmacy Network. If You need specialty medications, You must use one of the providers in the Specialty Pharmacy Network as Your specialty medication pharmacy. You may also be required to have the medication administered in certain settings or facilities. Specialty medication providers are experts in supplying medications and services to patients with complex health conditions. They will give You information about Your condition and the medications that have been prescribed to You. Please call Customer Service at (800) 237-2767 to find out which providers are in the Specialty Pharmacy Network program.

Mail order medications / Network Benefits
Your cost sharing for a prescription drug purchased at a retail or mail order pharmacy, will be the lower of the pharmacy's retail price for a prescription drug or Your cost-sharing amount as shown in the schedule of benefits. Your cost sharing for any prescription drug will apply to both the Plan's deductible, if any, and out-of-pocket maximum.

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
The Formulary is a list of medications provided from Our Pharmacy Services Vendor to help Us determine Your cost for certain prescriptions. The Formulary is reviewed by Our Pharmacy and Therapeutics Committee and is updated at least four (4) times per year. The presence of a drug on Our Formulary does not guarantee that You will be prescribed that drug by Your prescribing physician for a particular medical condition.

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 impact Your costs and coverage under this benefit. We will

You may view the Formulary at Our website 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 Specialty Drug Products may be required through a Mail Order Network Pharmacy. These Specialty Drugs fall under Tier 4 of our Formulary, however, not all Tier 4 drugs are Specialty Drugs. Mail order prescriptions will be eligible as written by the provider, up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size, or based on other Quantity or Supply Limits. Specialty Prescription Drug Products will be eligible as written by the provider, up to a consecutive 30-day supply of a Specialty Prescription Drug, unless adjusted based on the drug manufacturer's packaging size or based on other Quantity or Supply Limits. When a Specialty Prescription Drug Product is packaged or designed in a manner that provides more or less than a consecutive 30-day supply, the Copayment and/or Coinsurance that applies may be adjusted to reflect the number of days dispensed.

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

In order to find out which medications have a Quantity Limit restriction, refer to the Formulary at www.brighthealthcare.com.

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.brighthealthcare.com.

We do not require Pre-authorization for antiretroviral drugs including PrEP unless there are FDA approved therapeutic equivalents to prevent AIDS/HIV. We cover at least one therapeutic equivalent without a Pre-authorization requirement.

Step Therapy

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

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.brighthealthcare.com.

We do not require Step Therapy for antiretroviral drugs including PrEP unless there are FDA approved therapeutic equivalents to prevent AIDS/HIV. We cover at least one therapeutic equivalent without a Step Therapy requirement.

Exceptions

Exceptions 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
- For nonformulary drugs, drugs will be covered at the Tier 3 cost share for nonspecialty drugs or Tier 4 cost share for specialty drugs

Examples of exceptions are:

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

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

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

Drug Tiers

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

Tier 1: Mostly generic and low-cost preferred brand name drugs
Tier 2: Non-preferred generic drugs, preferred brand name drugs, and any other drugs recommended by Our pharmacy and therapeutics committee based on safety, efficacy, and cost.
Tier 3: Non-preferred brand name drugs or drugs that are recommended by Our pharmacy and therapeutics committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.
Tier 4: Biologics, drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost Us more than six hundred dollars ($600) net of rebates for a one-month supply.

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

Covered Medications and Products

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

- Coverage is limited to prescription products, prescribed by a legal prescriber. Prescription Medications are labeled as "Caution: Federal Law Prohibits Dispensing without a Prescription," "Rx Only," and/or where California 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.
- 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.
- Phenylketonuria (PKU) formulas and special food products for other inborn metabolic disorders are covered, and subject to the same deductibles, co-pays, and network providers as other prescription products, when used to treat PKU.
- Weight loss Drugs when Medically Necessary for the treatment of morbid obesity.
- Specialty Pharmaceutical medications, as defined by the plan when dispensed by our Specialty Pharmacy Network Supplier.
- Contraceptives medications, and various other products are covered for use as birth control at no cost to You. If contraceptive medications are prescribed to You for usage other than as birth control will apply the cost sharing amount as set forth in Our Formulary.
- Immunizations administered at a Network Pharmacy.
- AIDS vaccine, when approved.
- Appropriate pain management medications for terminally ill patients.
- Medications prescribed to treat emergency medical conditions while traveling outside the United States.
- Medications that were previously approved for coverage by the plan for a medical condition of the Member and the plan's prescribing provider continues to prescribe the drug for the medical condition, provided that the drug is appropriately prescribed and is considered safe and effective for treating the Member's medical condition.

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.

Off-label Use of Medications

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

Certain drugs may be used for the treatment of a life-threatening condition even though the drug has not been approved by the Food and Drug Administration (FDA) for treatment of the condition for which it is being used.

Drugs used for Off-Label purposes must be FDA-approved and prescribed by a Participating Provider for the treatment of a life-threatening condition, or for the treatment of a chronic and seriously debilitating condition, and must me Medically Necessary to treat that condition.

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: National Comprehensive Cancer Network Drug and Biologics Compendium, American Hospital Formulary Service's Drug Information, Elsevier Gold Standard's Clinical Pharmacology, or the Thomson Microdex DrugDex. A Prescription Drug Product includes a drug approved by the FDA prescribed to treat cancer during certain clinical trials as described in the Agreement.

The drug may also be allowed for Off-Label use if the purpose has been recognized by two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

Oral Anticancer Medication

Covered Health Services under this section include self-administered oral anticancer medication that has been approved by the Federal Food and Drug Administration (FDA) and is used to kill or slow the growth of cancerous cells. Self-administered oral 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 self-administered oral anticancer medications is not a replacement for other cancer medications.

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

Your total cost-share for a prescribed oral anticancer medication will not exceed $250 for a 30-day supply.

Pain Management and Schedule II Prescription Drugs

A pharmacist may dispense a Schedule II controlled substance, as listed in State Law, as a partial fill if requested by You or the prescriber. If a pharmacist dispenses to You a partial fill (a quantity less than the entire Prescription) of a Schedule II Prescription Drug, the Pharmacy will retain the original Prescription, with a notation of how much of the Prescription has been filled, until the Prescription has been fully dispensed. The total quantity dispensed will not exceed the total quantity Your provider prescribed to you. Any subsequent refill must occur at the Pharmacy where the original Prescription was partially filled original Prescription is completely dispensed. The Pharmacy will not dispense the full Prescription more than 30 days after the date on which the Prescription was written. Thirty-one days after the date on which the Prescription was written, the Prescription will expire and no more of the Drug will be dispensed to You without a subsequent Prescription.

We will prorate Your cost sharing for a partial fill of a Prescription of an oral, solid dosage form of Schedule II Prescription Drug,

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. This is calculated based on the days between refills, assuming the enrollee is following the daily dosage. 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. If additional refills are needed, the Exceptions process shown earlier in this Prescription Drugs section may be used.

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

Preventive Medications

Covered Health Services under this section include preventive medications in accordance with the A or B recommendations of the U.S. Preventive Services Task Force:

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

What You Must Pay

Cost-sharing for prescription drugs will be the lower of the pharmacy's retail price for a prescription drug or the

applicable cost-sharing amount for the appropriate drug tier on our Formulary. The applicable cost-sharing amount You pay will apply to both the deductible, if any, and the out-of-pocket maximum limit.

Preventive Care/Screenings/Immunizations
Covered Health Services under this section include preventive health care services in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, and/or as required by State or federal law.

When these services are received from a Network Provider, they are covered at 100% of the Allowable Amount and are not subject to the Annual Deductible, Copayment, or Coinsurance:

- Abdominal aortic aneurysm screening for men ages 65-75 years old and who have ever smoked;
- Aspirin preventive medication: initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not an increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.
- Bacteriuria screening with urine culture for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, if later;
- Blood pressure screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
- BRCA risk assessment testing for women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing;
- Breast cancer screening mammography for women with or without clinical breast examination;
- 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;
- Cervical cancer screening every year with cervical cytology and a human papillomavirus (hrHPV) test;
- 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 50 years and continuing until age 75 years. At home non-invasive stool DNA colorectal screening tests are subject to Medical Necessity and Pre-Authorization requirements.
- 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;
- Hemoglobinopathies screening for sickle cell disease in newborns;
- Hepatitis B screening in pregnant women at their firs prenatal visit, and in nonpregnant adolescents and adults who are at high risk for infection.

- Hepatitis C screening in persons at high risk for infection, and also a one-time screening for adults born between 1945 and 1965;
- HIV screening and counseling;
- Hypothyroidism screening for congenital hypothyroidism in newborns;
- 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.
- Pediatric Preventive Care as adopted by the American Academy of Pediatrics including periodic health evaluations, laboratory services, and immunizations.
- 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.
- Prostate specific antigen testing and prostate screening, including digital rectal exam;
- 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 U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessations to adults who use tobacco.
- Tobacco use counseling and interventions for pregnant women. The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.
- Tobacco use interventions for children and adolescents. The USPSFT 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 well-child care.
- 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 U.S. Preventive Services Task Force website: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

Note: *If the Covered Person receives the same preventive screening more than once in the USPSTF's recommended timeline, benefits for the additional screening will be payable under the Lab, X-Ray and Diagnostics – Outpatient benefit and are subject to any applicable Annual Deductible, Copayment, or Coinsurance. You may review services and recommended timelines at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.*

Prosthetic Devices
Covered Health Services under this section include external prosthetic devices that replace a limb or a body part, limited to:
- Prosthetics will be covered in accordance with Medicare guidelines and criteria.
- Bionic, myoelectric, microprocessor-controlled, and computerized Prosthetics
- Artificial face, eyes, ears, and noses.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics to restore a method of speaking after laryngectomy.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

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

The prosthetic device must be ordered or provided by, or under the direction of a Physician.
Coverage is available for repairs and replacement, except that:
- There are no Benefits for repairs due to misuse.
- There are no Benefits for replacement due to misuse or loss.

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

Radiation
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 education is required for a disease in which patient self-management is an important component of treatment.
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 Agreement*.

Reconstructive Procedures
Covered Health Services under this section include reconstructive procedures performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

- To improve function.
- To create a normal appearance, to the extent possible.

Cosmetic Surgery means surgery performed to alter or reshape normal structures of the body in order to improve appearance, and are excluded from coverage.

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

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

Rehabilitation Services
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.

Outpatient Rehabilitative Services
Covered Health Services under this section include the following short-term outpatient Rehabilitative Services:

- Physical therapy;
- Occupational therapy; and
- Speech therapy.

Inpatient Rehabilitative Services
Covered Health Services under this section include services and supplies provided during an Inpatient Stay in an Inpatient Rehabilitation/Habilitation Facility.

Coverage is available for:

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

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

Please note that coverage is available only if You will receive skilled care services that are not primarily Custodial Care.

Inpatient Rehabilitation Treatment is limited to 30 days per calendar year.

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 Agreement. 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 Agreement*.

Skilled Nursing
Covered Health Services under this section include services and supplies provided during an Inpatient Stay at a 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 Physician Fees for Surgical and Medical Services provision of the *Benefits/Coverages (What is Covered) section of this Agreement*.)
- Medically Necessary Supplies
- Drugs prescribed by a Physician as part of the plan of care in the plan skilled nursing facility in accordance with Our drug formulary guidelines if they are administered in the skilled nursing facility by medical personnel;
- Skilled care, skilled nursing and skilled teaching 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 You will receive skilled care services that are not primarily Custodial Care.

Coverage is limited to 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.

Transplant
Covered Health Services under this section include organ and tissue transplants when ordered by a Physician. Coverage is available for transplants when the transplant meets the definition of a Covered Health Service and is not an Experimental, Investigational, or Unproven Service. Services may be required to be rendered at a Center of Excellence facility.

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

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

Coverage will not be denied, if otherwise available under this Agreement, for the costs of transplantation services based upon HIV status.

Treatment for Temporomandibular Joint Disorders (TMJ)
Covered Health Services under this section include Medically Necessary services for the treatment of TMJ, including diagnostic X-rays, lab testing, physical therapy, and surgery.

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

Urgently needed services are those services necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including Pregnancy, for which treatment cannot be delayed until the Member returns to Our service area.

Urgently needed services includes maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the Member's reasonable belief that she has a Pregnancy-related condition for which treatment cannot be delayed until the Member returns to Our service area.

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 Visits – Primary or Specialty Care to Treat an Injury or Illness* provision of the *Benefits/Coverages (What is Covered) section of this Agreement*.

Vision Services
This Plan will cover contact lenses for aniridia and aphakia when prescribed by an In-Network Physician or In-Network Optometrist. We cover up to six (6) Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar Year and up to two (2) Medically Necessary aniridia contact lenses per eye (including fitting and dispensing) per calendar year at no charge.

Vision Services for Children
This benefit is only available when services are received from a Network Provider. There are no Benefits for services received from a Non-Network Provider.

For the purposes of this Benefit, coverage is limited to Enrolled Children through the last day of the month in which the child turns age 19.

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.

Covered Health Services also include:

- Dilation, if professionally indicated
- Lenses
    - Choice of glass, plastic or polycarbonate lenses
    - All lens powers:
        - Single
        - Conventional (lined) bifocal
        - Conventional (lined) trifoc
        - Lenticular
- Medically necessary contacts
    - Dispensed in lieu of other eyewear
    - Contact lenses may be determined to be medically necessary in the treatment of the following conditions: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism)
- Contacts (for refraction)
    - Extended Wear Disposable: Up to 6 month supply or 2 week disposable, single vision spherical or toric contact lenses
    - Daily Wear / Disposable: Up to 3 month supply of daily disposable, single vision spherical contact lenses
    - Conventional: 1 pair from selection of provider designated contact lenses
    - Medically Necessary: Paid in Full
- Low vision benefit (Pre-authorization may be required).
    - Exam
    - Device coverage

Wigs
Covered Health Services under this section includes coverage for one (1) wig per calendar year when needed following cancer treatment.

X-Ray, and Diagnostic Imaging
Covered Health Services under this section include 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.

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

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 Agreement,* those limits are stated in the corresponding category in the *Schedule of Benefits (Who Pays What) section of this Agreement*. 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 Agreement* under the heading *Benefit Limits*. Please review all limits carefully, as We will not pay Benefits for any of the services, treatments, items, or supplies that exceed these Benefit limits.

BENEFIT EXCLUSIONS

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

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

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 Agreement*.

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

Alternative Treatments

Health care services excluded under this provision include the following:

- 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.

This exclusion does not apply to Pre-authorized Medically Necessary covered health for the treatment of Mental Health or Substance Use Disorders.

Chiropractic Care

Chiropractic Care is excluded from coverage under this plan.

Custodial or Domiciliary Care

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

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

This exclusion does not apply to Pre-authorized Medically Necessary covered health services provided to an enrollee residing in a Custodial Care facility, or to Pre-authorized Medically Necessary covered health services for the treatment of Mental Health and Substance Use Disorders.

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) 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 this Agreement, 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 covered under Section 6, Oral Surgery and/or Pediatric Dental Care. Examples include:
- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

Dental implants, bone grafts, and other implant-related procedures are excluded. 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 as an integral part of reconstructive surgery.

Routine dental care for adults is excluded.

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

This exclusion does not apply to dental services required for the direct treatment of a medical condition such as treatment for cleft lip or cleft palate for which Benefits are described in Section 6.

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
- 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.

Directed Blood Donations
Directed Blood Donations are excluded from coverage.

Employer or Governmental Responsibility
Services for which the financial responsibility resides with an employer or a local, state, or federal government agency are not covered, except when coverage under this plan is expressly required by federal or state 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.

If an Enrollee has a life-threatening or seriously debilitating condition and the requested treatment is not a Covered Health Service because it is Experimental or Investigational, the Member may request an independent medical review. See the section titled Independent Medical Review Process for further details.

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 Agreement*.

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

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
- 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 Agreement.

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 Care/Screenings/Immunizations for information about Genetic Testing that is covered by the plan.

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

Infertility & Reproductive Services
Health care services excluded are:
- Services for treatment of involuntary infertility;
- Services to reverse voluntary, surgically induced infertility;
- Services related to the diagnosis and treatment of infertility, other than Medically Necessary iatrogenic fertility preservation services.
- 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, except for storage and retrieval related to iatrogenic fertility preservation services. Refer to Section 6 - Benefits/Coverage (What is Covered), Fertility Preservation and Infertility Treatment. Examples of excluded materials 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:
- Elastic stockings
- Ace bandages
- Antiseptics

This exclusion does not apply to Durable Medical Equipment for home use.

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 nutritional education is required for a disease in which patient self-management is an important component of treatment.
- 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).

This exclusion does not apply to Medically Necessary Nutritional Counseling for the treatment of Mental Health and Substance Use Disorder including anorexia nervosa or bulimia.

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 - Exclusions
We will not pay Benefits for:
- 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.
- 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.

- 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 Member 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, except as provided under the Dental Anesthesia provision under Section 6 - Benefits/Coverage (What is Covered). Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
- extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- laboratory processed crowns for teeth that are not developmentally mature.
- endodontic endosseous implants.
- charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility, except as provided under the Dental Anesthesia provision under Section 6 - Benefits/Coverage (What is Covered).
- 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 Member 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.
- the initial placement of any prosthodontic appliance or implant, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Member 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.
- the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- dental case management motivational interviewing and patient education to improve oral health literacy.
- non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

Personal Care, Comfort, or Convenience

Items excluded under this provision include the following:

- Television
- Telephone
- Beauty/barber services
- Guest service
- 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. This exclusion does not apply to speech prosthetics.
- 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 surgery or treatment performed to alter or reshape normal structures of the body in order to improve appearance. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure, except for Medically Necessary services related to prior cosmetic breast implant complications. **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). This exclusion does not include breast augmentation for the treatment of gender dysphoria.
- 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 Agreement*, or to breast augmentation for the treatment of gender dysphoria
- 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.

Prescription Drug Exclusions
Certain Health Care Services that are excluded under Your Prescription Drug benefit may be covered under Your medical benefit. We have provided that information below.

Health care services excluded under Your Prescription Drug benefit 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, such as contraception and tobacco cessation related medications that would be covered under Preventive Care.
- Medications for which the condition or services are excluded under your Schedule of Benefits or the Agreement.
- 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, unless otherwise required by law or displaced due to a

declared state of emergency.

- Medications prescribed solely for cosmetic purposes.
- Human Growth Hormone prescribed for short stature, unless Medically Necessary and prior authorized by the Plan.
- Compound Drugs unless all the ingredients are FDA-approved, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to the non-FDA approved Compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants as determined by Our pharmacy benefit manager.
- Medications which are labeled or deemed Investigational or Experimental, including regimens that are unproven, except when Enrollee has a life-threatening or seriously debilitating condition, and the medication is appropriate for the Enrollee based on the determination of the Independent Medical Review process. See Experimental, Investigational, or Unproven Services section for further details.
- 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 Health or Substance Use Disorder 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. In the event of a dispute as to whether an injury or illness is work-related and eligible for worker's compensation, We will arrange for care until the dispute is resolved if the Enrollee agrees, in writing, to reimburse Us 100% of the benefits provided if the illness or injury is found to be the responsibility of worker's compensation. We will not provide benefits for services for work-related illness or injury if the Enrollee fails to file a claim to Us within the time period allowed by law or fails to comply with other applicable provisions of law under the Worker's Compensation Act.
- Any product dispensed for the purpose of appetite suppression or weight loss, except when prescribed and Medically Necessary for the treatment of morbid obesity or when medically necessary for the treatment of mental health or substance use disorders.
- Prescribed and non-prescribed outpatient supplies, other than diabetic supplies; and inhaler spacers, nebulizers and peak flow meters as Medically Necessary for the treatment of asthma or as described in the Benefits/Coverage (What is Covered) section of this Agreement.
- General vitamins except as described under the Preventive Care/Screenings/Immunizations of the Benefits/Coverage (What is Covered) section of this Agreement.
- Medication prescribed for the treatment of hair loss, except when medically necessary for the treatment of mental health or substance use disorders.
- Off-label use of medications unless required by Law, then allowed in accordance with Law; or for the treatment of a life-threatening condition as described under Section 6 - Benefits/Coverage (What is Covered).
- Biological sera, blood, blood products or plasma. These items would be covered under Your medical benefits in the event of a hospitalization. Please refer to Section 6 - Benefits/Coverage (What is Covered), Hospital and Free-Standing Facility Services
- Oxygen, Medical Devices or Equipment, unless specifically listed as covered. These items would be covered under Your medical benefits. Please refer to Section 6 - Benefits/Coverage (What is Covered), Durable Medical Equipment.
- 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. This exclusion does not apply to Medically Necessary Nutritional Counseling or nutritional products for the treatment of Mental Health and Substance Use Disorders, or as described in the Benefits/Coverage (What is Covered) section of this Agreement.
- Medications used to treat Erectile Dysfunction, except when medically necessary for the treatment of mental health or substance use disorders..
- Topical medications for the treatment of onychomycosis of the toenails, unless Medically Necessary for the treatment of a medical condition.
- Allergy serum. This would be covered under Your medical benefits and administered in a Physician's office. Please refer to Section 6 - Benefits/Coverage (What is Covered), Physician's Visits – Primary or Specialty Care to Treat an Injury or Illness.
- Medications used solely for the treatment of Infertility, except as covered for fertility preservation services.
- Over-the-counter medications except for tobacco-cessation drugs and contraceptives or as otherwise described under Section 6 - Benefits/Coverage (What is Covered), Preventive Care/Screenings/Immunizations.

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging.
- Marijuana, including but not limited to medical marijuana for any reason. This exclusion does not apply to Medically Necessary cannabis-derived drugs or synthetic cannabis-related drug products approved by the FDA to treat a disease or condition.

Prescription Drugs Limitations
Health care services limited under this provision include the following:
- 90-day supply of covered medications per prescription is allowed, other quantity limits may be applied to claims, with the exception for a 12-month supply of FDA-approved self-administered hormonal contraceptives.
- Certain medications are subject to Our utilization review process and quantity limits. For most medications, 90-day supplies will be covered when filled at a network pharmacy. No more than a 30-day supply of Specialty Medications will be covered and dispensed at a time.
- If You request a brand medication when there is a generic equivalent available, You will be responsible for the Tier 2 copay or cost share plus the difference in drug cost between the brand and generic. For example, Your Tier 2 copay may be $25. The generic drug on the formulary has a contracted rate of $100, while the nonformulary brand drug has a contracted rate of $250. You will be responsible for the difference between the brand and generic cost ($250-$100=$150) plus the required copayment ($25), so Your total cost in this example would be $175 ($150+ $25=$175).
- If a Provider requests that a brand medication be dispensed as written and approved through the exception process as medically necessary, the medication will be covered at the nonformulary benefit (Tier 3 cost share for non-specialty drugs or Tier 4 cost share for specialty drugs).
- The member copayment for a medication will not exceed the cost of the medication.
- If a member copayment is required, you must pay one member copayment for each 30-day supply, or portion thereof, except for Mail Order Medications.

Private Duty Nursing
Services for nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting is excluded from coverage under this plan.

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, except when related to gender dysphoria such as genital reconstructive surgery where those interventions and treatments comply with all other provisions of the Plan, such as Pre-authorization.
- 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.
- Treatment of the teeth, jawbone except as expressly required by law or specifically stated as a covered under Section 6 - Oral Surgery.
- 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 provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a freestanding or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a freestanding or Hospital-based diagnostic facility, when that Physician or other provider:
  - Has not been actively involved in Your medical care prior to ordering the service, or
  - Is not actively involved in Your medical care after the service is received.

This exclusion does not apply to mammography.

Services Received Outside of Your Coverage Period
Health services received prior to your effective date, or after the date Your coverage ends are excluded except as allowed through the Continuity of Care and/or Extension of Benefits provision of this Agreement. Refer to Section 5 - How to Access Your Services and Obtain Approval of Benefits to review these provisions.

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, unless otherwise required to be covered under the law.

Transplantation Services
Health care services excluded under this provision include the following:
- Health services for organ and tissue transplants, except those described under this Agreement;
- 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 Agreement.)
- 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, except as those described in the Travel Expenses provision of the *Benefits/Coverage (What is Covered)* section of this Agreement.

Types of Care
Health care services excluded under this provision include the following:
- Respite care, except as covered under the *Hospice Care* provision of the *Benefits/Coverages (What is Covered) section of this Agreement*
- 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.
- 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 in excess of the Allowable 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.
- Court-ordered testing, except for mental health or Substance Abuse testing or treatment as required by state law.
- Gym fees or memberships.
- Health services and supplies that do not meet the definition of a *Covered Health Service* - see the *Definitions* section.
- Long-term care/Nursing home care
- Long-term (more than 30 days) storage of products such as cryopreservation of tissue, blood, and blood products, except as needed for organ transplant/donation services, or as covered under the Fertility Preservation Services provision for the treatment of iatrogenic infertility.
- Medical services and procedures that are not legal.
- Physical, psychiatric or psychological exams, testing, vaccinations or immunizations (not including preventive well-child visits and services), or treatments that are otherwise covered under this Agreement 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 Agreement.
  - 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.
- Virtual colonoscopy including CT colonography and capsule endoscopy and colonography
- Virtual coronary angiography and coronary calcium scans

Section 8 - Member Payment Responsibility

YOUR RESPONSIBILITIES

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

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

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

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

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

OUR RESPONSIBILITIES

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

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

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

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

IF YOU RECEIVE COVERED HEALTH SERVICES FROM A NETWORK PROVIDER

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

ASSIGNMENT OF BENEFITS

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

REIMBURSEMENT PROVISIONS

If You have paid for a Covered Service or prescription drug that was approved or does not require approval, We will pay you back. You must submit your claim for reimbursement within twelve (12) months from the date You made the payment.

REQUIRED CLAIM INFORMATION

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

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

CLAIM FORMS

Out-of-Network emergency or urgent care claims must be submitted to Us within 180 days from the date(s) of service(s). We must receive the claim by midnight PT on the 180th day from the date of service. You or Your Treating Provider must claim benefits by providing Us the proper claim forms which itemize services or supplies received.

You may request the required claim forms by calling Customer Service at the number listed on Your identification card.

When a request for a claim form or the notice of a claim is provided to Us, We will provide the claimant or Member 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 Agreement. Foreign claims must be translated in U.S. currency prior to being submitted to the Plan for payment.

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, Member, 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. 07

TIMELY FILING

Claims for Covered Health Services from a Non-Network or Non-Participating Provider must be submitted to Us within one-hundred eighty (180) 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 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:

Claim Submissions and Correspondence Address:

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

TIME OF PAYMENT OF CLAIMS

Claims payable under this Agreement for any loss, other than loss for which this Agreement provides periodic payment, will be paid within forty-five (45) days of receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Agreement 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 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 *Agreement*.
- The plan may not pay for all treatments You or Your Physician may believe are necessary. If the plan does not pay, You will be responsible for the cost.

OUR RELATIONSHIP WITH PROVIDERS

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

YOUR RELATIONSHIP WITH PROVIDERS

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

- You are responsible for choosing Your own provider.
- You are responsible for paying, directly to Your provider, any amount identified as Your responsibility, including Copayments, Coinsurance, any Annual Deductible, and any amount that exceeds the Allowable 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 taken into account in determining Your Copayments or Coinsurance.

INSPECTION OF AGREEMENT

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

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

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 Agreement, 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 Agreement, 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 Agreement 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 Agreement, 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 Agreement, We and Our related entities may use and transfer the information gathered under this Agreement 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.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to You upon request. Contact us at the number listed in Section 2 of this Agreement and on Your ID Card for a copy of our policies and procedures for preserving Your medical record confidentiality.

NONDISCRIMINATION

We do not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, language, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, or genetic information.

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 Agreement or to any change of Beneficiary, or beneficiaries, or to any other changes in this Agreement.

EXAMINATION AND AUTOPSY

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

INTEGRATION OF MEDICARE BENEFITS

If You are eligible for Medicare, Your Medicare eligibility will not affect the Covered Services that would be covered under this Agreement, except as follows:

- Your Medicare coverage will be applied first (primary) to any services covered by both Medicare and this Agreement.
- If You receive a service that would be covered both by Medicare and this Agreement, 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 Agreement. All benefits payable under this Agreement are subject the applicable deductible, copayment and/or coinsurance for the Covered Health Service as outlined in the Schedule of Benefits.
- If You or a Dependent are entitled to Medicare or if a Member of this Policy becomes eligible for Medicare by reason of age, disability, End Stage Renal Disease or any other eligibility category, We will consider what Medicare would pay to the extent permitted by law. This means that We will determine coverage and payment available to the Member after identifying the amounts that Medicare would pay.
- If You or a Dependent are eligible for Medicare, We will estimate the amount Medicare would have paid and reduce benefits by this amount for any Member who is eligible to enroll in Medicare but is not enrolled.

ELIGIBILITY FOR MEDICARE

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

NON-DUPLICATION OF MEDICARE

We will not provide benefits that duplicate any benefits You would be entitled to receive under Medicare. This exclusion applies to all Parts of Medicare in which You enroll without paying additional Premium. However, if You

have to pay an additional Premium to enroll in Part A, B, or C or D of Medicare, this exclusion will apply to the particular Part(s) of Medicare for which You must pay only if You have enrolled in the Part(s).

However, if You have Medicare, Your Medicare coverage will not affect the Covered Services covered under this Agreement, except as follows:

- Your Medicare coverage will be applied first (primary) to any services covered by both Medicare and this Agreement.
- If You receive a service that is covered both by Medicare and this Agreement, Our coverage will apply only to the Medicare Deductibles, Coinsurance and other charges for Covered Services that You must pay above what is payable by Your Medicare coverage.

For a particular claim, the combination of Medicare benefits and the benefits We will provide under this Agreement for that claim will not be more than the billed charge for the Covered Service You received.

We will apply any expenses paid by Medicare for Covered Services covered under this Agreement toward Your Deductible, except expenses paid by Medicare Part D.

COORDINATION OF BENEFITS (COB)

This Coordination of Benefits ("COB") provision applies when a Member has health care coverage under more than one Plan. All of the benefits provided under This Plan Agreement are subject to this provision. For purposes of this COB provision, Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the "Primary Plan". The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the "Secondary Plan". The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Pediatric dental essential health benefits
For provision of pediatric dental essential health benefits, this Plan is considered primary.

Definitions (applicable to this COB provision)

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

1. Plan includes:

    - Group, blanket, or franchise insurance coverage.
    - Service plan contracts, group practice, individual practice and other prepayment coverage,
    - Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, and
    - Any coverage under governmental programs and any coverage required or provided by any statute.

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

Each contract for coverage under (1) or (2) shown above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

"**This Plan**" means that portion of this Agreement that provides the benefits that are subject to this COB provision and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the Member has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense. When there are more than two Plans covering the Member, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

"**Allowable Expense**" is a health care expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any Plan covering the Member. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Member is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If a Member is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

3. If a Member is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

4. If a Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because a Member has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

"**Claim Determination Period**" means a calendar year.

Order of Benefit Determination Rules
(A) When a Member is covered by two or more Plans, these Order of Benefit Determination rules apply in determining the benefits as to a Member covered under This Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such Member during such period, the sum of:

(i) the value of the benefits that would be provided by This Plan in the absence of this provision, and

(ii) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.

(B) As to any Claim Determination Period to which this provision is applicable, the benefits that would be provided under This Plan in the absence of this provision for the Allowable Expenses incurred as to such Member during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in paragraph (C), shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been made therefore.

(C) If (i) another Plan which is involved in paragraph (B) and which contains a provision coordinating its benefits with those of This Plan would, according to its rules, determine its benefits after the benefits of This Plan have been determined, and (ii) the rules set forth in paragraph (D) would require This Plan to determine its benefits before such other Plan, then the benefits of such other Plan will be ignored for the purposes of determining the benefits under This Plan.

(D) For the purposes of paragraph (C), use the first of the following rules establishing the order of determination, which applies:

(1) The benefits of a Plan which covers the Member on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such Member as a dependent, except that, if the Member is also a Medicare beneficiary and as a result of the rules established by Title XVIII of the Social Security Act (42 USC 1395 et seq.) and implementing regulations, Medicare is (i) secondary to the Plan covering the Member as a dependent and (ii) primary to the Plan covering the Member as other than a dependent (e.g., a retired employee), then the benefits of the Plan covering the Member as a dependent are determined before those of the Plan covering that Member as other than a dependent.

(2) Except for cases of a Member for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a Plan which covers the Member on whose expenses claim is based as a dependent of a Member whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a Plan which covers such Member as a dependent of a Member whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this subparagraph regarding dependents, which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this subparagraph shall not apply, and the rule set forth in the Plan which does not have the provisions of this subparagraph shall determine the order of the benefits.

(3) Except as provided in subparagraph (5), in the case of a Member for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

(4) Except as provided in Subparagraph (5), in the case of a Member for whom claim is made as a Dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.

(5) In the case of a Member for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding Subparagraphs (3) and (4), the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

(6) Except as provided in Subparagraph (7), the benefits of a Plan covering the Member for whose expenses claim is based as a laid-off or retired employee, or dependent of such Member, shall be determined after the benefits of any other Plan covering such Member as an employee, other than a laid-off or retired employee, or dependent of such Member;

(7) If either Plan does not have a provision regarding laid-off or retired employees, which results in each Plan determining its benefits after the other, then the rule under subparagraph (6) shall not apply;

(8) If a Member whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

- First, the benefits of a Plan covering the Member as an employee, member, or subscriber, or as that Member's dependent;
- Second, the benefits under continuation coverage. If the other Plan does not have the rules described above, and if, as a result, the Plans do not agree on the order of benefits, the rule under this subparagraph is ignored.

(9) When Subparagraphs (1) through (8) do not establish an order of benefit determination, the benefits of a Plan which has covered the Member on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such Member the shorter period of time.

(E) When this provision operates to reduce the total amount of benefits otherwise payable as to a Member covered under This Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of This Plan.

Effect On The Benefits Of This Plan
When a claim under a Plan with a COB provision involves another Plan, which also has a COB provision, the carriers involved shall use the above rules to decide the order in which the benefits payable under the respective Plans will be determined.

In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within 24 hours after the prior Plan terminated. Thus, neither a change in the amount or scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another (e.g., single employer to multiple employer Plan, or vice versa, or single employer to a Taft-Hartley Welfare Plan) would constitute the start of a new Plan for purposes of this instruction.

If a claimant's effective date of coverage under a given Plan is subsequent to the date the carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, in the absence of specific information to the contrary, the carrier shall assume, for purposes of this instruction, that the claimant's length of time covered under that Plan shall be measured from claimant's effective date coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier shall require the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time his coverage under that Plan has been in force.

It is recognized that there may be existing group plans containing provisions under which the coverage is declared to be "excess" to all other coverages, or other COB provisions not consistent with this rule. In such cases, plans are urged to use the following claims administration procedures: A group plan should pay first if it would be primary under the COB order of benefits determination. In those cases where a group plan would normally be considered secondary, the plan should make every effort to coordinate in a secondary position with benefits available through any such "excess" plans. The plan should try to secure the necessary information from the "excess" plan.

Right to Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan

and other Plans covering the person claiming benefits. Each person claiming benefits under This Plan must give Us any facts it needs to apply those rules and determine benefits payable.

Facility of Payment
A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services. To the extent of such payments, the Plan shall be fully discharged from liability under This Plan.

Right of Recovery
If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We paid or for whom We had paid, or any other person or organization that may be responsible for the benefits or services provided for the Member. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes
If You believe that We have not paid a claim properly, You should first attempt to resolve the problem by contacting Us. Follow the steps described in Section 12 – Grievances and Appeals. . If You are still not satisfied, You may call the Department of Managed Health Care (DMHC) for instructions on filing a consumer complaint. Call 1 (888) 466-2219, or visit Department of Managed Health Care (DMHC) website at www.dmhc.ca.gov.

By electing coverage or accepting benefits under this Agreement, all Members legally capable of contracting, and the legal representatives for all Members incapable of contracting, agree to all provisions of this Agreement.

Third-party liability
You agree that, if Covered Services are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, if You are made whole for all other damages resulting from the wrongful act or omission before We are entitled to reimbursement, then You shall:

- Reimburse Us for the reasonable cost of services we had paid to the extent permitted by California Civil Code section 3040 immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and
- Fully cooperate with Our effectuation of lien rights for the reasonable value of services provided by Us to the extent permitted under California Civil Code section 3040. Our lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

We shall be entitled to payment, reimbursement, and subrogation (recover benefits paid when other insurance provides coverage) in third party recoveries and You shall cooperate to fully and completely assist in protecting Our rights including providing prompt notification of a case involving possible recovery from a third party.

WORKERS' COMPENSATION

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

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

You must pursue Your rights under the Workers' Compensation Act or any other laws that may apply to Your situation. This includes filing an appeal with the California 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 California 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 California 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 plans, 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:

- That 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.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the instigation of legal action against You.
- That We have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That Benefits paid by Us may also be considered to be Benefits advanced.
- That 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.
- That, 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.
- That 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.
- That We will not be obligated in any way to pursue this right independently or on Your behalf.
- That 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.

- That 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 Agreement.
- 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 Agreement. 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 is a period of at least 31 consecutive days beginning the day the Notice of Start of Grace Period is dated.

A Grace Period of 3 months for individuals receiving federal subsidies will be allowed for the payment of all outstanding premiums. If the entire 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. We will continue to provide coverage during the grace period and will pay for claims incurred during the first month of Your grace period. During the second and third month of the grace period, Your coverage will be suspended and You will not be eligible for benefits under Your Agreement unless you pay all premiums due before the end of the grace period.

For non-subsidized Members, a 31-day grace period will be allowed for the payment of all outstanding premiums. If the full balance of outstanding premium is not paid within Your grace period, coverage will end on the last day for which You have paid Your premium. We will continue to provide coverage during the grace period.

If You do not pay the required premiums by the end of the grace period, Your coverage will be cancelled. We will provide You notice of Your nonpayment before cancelling Your coverage. We will not pay for any services received on or after the date Your coverage ends.

LIMITATION OF LEGAL ACTION

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

LIABILITY OF SUBSCRIBER TO PAY PROVIDERS

In accordance with Our Provider agreements and applicable statutes, You will not be required to pay any In-Network Provider for amounts owed to that Provider by Us (other than your applicable Deductible, Copayment, and Coinsurance amounts), even in the unlikely event that We fail to pay the Provider.

You may be liable for charges to Out-of-Network Providers, or for any amounts over the Allowable Amount.

CONFORMITY WITH STATE STATUTES

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

FRAUDULENT ACTS NOTICE

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to the health care service plan for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of services and civil damages. Any person, company or agent of who knowingly provides false, incomplete, or misleading facts or information to a Member or claimant for the purpose of defrauding or attempting

to defraud the Member or claimant with regard to a settlement or award payable by the health care service plan shall be reported to the DMHC.

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

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

If fraud is suspected, contact Us at the *Customer Service* number listed in Section 2 of this Agreement 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 Agreement 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 Agreement, in the absence of fraud, no misstatements made by the Subscriber in the enrollment application may be used by Us to cancel this Agreement 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 health plan coverage.

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

NOTICES

All notices are considered sent to and received by You when deposited in the United States mail with postage prepaid and addressed to the address on file with Us. You may choose to receive electronic delivery of all Agreement, premium, or other notices related to this Agreement by calling Customer Service at the phone number listed on Your ID card, or by opting in through the Bright HealthCare Member Hub at www.brighthealthcare.com.

PUBLIC POLICY PARTICIPATION PROCEDURE

This procedure enables Members to participate in establishing the public policy of Bright HealthCare. Members may apply to participate by contacting Us directly at (844) 926-4524. This Procedure is not to be used as a substitute for the Grievance procedure, complaints, inquiries or requests for information. Public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public (California Health and Safety Code, Section 1369).

Bright HealthCare has established a standing committee responsible for creating the public policy of the plan. The standing committee's recommendations and reports are regularly reported to the governing board. The governing board considers the recommendations of the standing committee and records any action taken, in its minutes. Upon request, We will provide Members who have initiated a public policy issue with the appropriate extracts of the minutes within thirty (30) business days after the minutes have been approved.

TIMELY ACCESS TO CARE

We offer timely access for scheduling Your appointments with a Participating Providers as required by state law, as shown in the table below.

Appointment Type	**Access Standard**
Urgent care appointments not requiring Prior Authorization (including primary care or Specialist Physician)	Within 48 hours
Urgent care appointments requiring Prior Authorization (including primary care or Specialist Physician)	Within 96 hours
Non-urgent appointments for primary care	Within 10 business days

Non-urgent appointments with Specialist Physician	Within 15 business days
Non-urgent appointments with a non-physician mental health care providers	Within 10 business days
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness or other health conditions	Within 15 business days
Telephone triage waiting time	Not to exceed 30 minutes

OTHER INFORMATION YOU SHOULD HAVE

We have the right to change, interpret, modify, withdraw, add Benefits, or terminate this Agreement, without Your approval, as permitted by law. We must notify You of material changes to this Agreement at least 60 days in advance of the change. Reasons for termination of this Agreement can be found under Section 11, Termination/Nonrenewal/Continuation.

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

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

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 Agreement on or before the due date.

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

Section 11 - Termination/Nonrenewal/Continuation

TERMINATION OF BENEFITS

This section describes how coverage for the Member can be canceled, rescinded, suspended or not renewed.

GENERAL INFORMATION ABOUT WHEN COVERAGE ENDS

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained below, as permitted by law. We will provide the required written notice of termination prior to cancellation of this Agreement.

If You feel that an enrollment or subscription has been cancelled or not renewed because of the enrollee's or subscriber's health status or requirements for health care services, You may request a review of cancellation by the Department of Managed Health Care (DMHC). You may contact the DMHC at (888) 466-2219, or at the DMHC website at www.dmhc.ca.gov.

Termination Based on Eligibility

In the event We terminate Your coverage based on one of the events below, We will provide You with written Notice of End of Coverage no later than five (5) calendar days after the date the coverage ended:

- You no longer reside, live or work in Our service area.
- An Enrolled Dependent Child reaches the limiting age. If the Dependent child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and is chiefly dependent upon the Subscriber for support and maintenance, the Dependent can remain as a Dependent Child under the Agreement. At least 90 days prior to the child reaching the limiting age, We shall notify the Subscriber that the Dependent Child's coverage will terminate upon attainment of the limiting age unless the Subscriber submits proof of such dependency within 60 days of receipt of the notice.

Cancellation of Agreement

In the event We terminate Your coverage based on one of the events below, We will provide You with a Notice of Cancellation within the timeframe(s) described:

- We decide not to renew all of Our individual or family plans in the State of California. In this case, We will provide you a Notice of Non-renewal at least 180 days before the Agreement is terminated.
- We terminate the Agreement due to non-payment of premiums. We will send you a Notice of Start of Federal Grace Period to advise that a payment delinquency has triggered a Grace Period.
    - A Grace Period of 3 months for individuals receiving federal subsidies will be allowed for the payment of all outstanding premiums. If the entire 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. We will continue to provide coverage during the grace period and will pay for claims incurred during the first month of Your grace period. During the second and third month of the grace period, Your coverage will be suspended and You will not be eligible for benefits under Your Agreement unless you pay all premiums due before the end of the grace period.
    - For non-subsidized Members, a 31-day grace period will be allowed for the payment of all outstanding premiums. If the full balance of outstanding premium is not paid within Your grace period, coverage will end on the last day for which You have paid Your premium. We will continue to provide coverage during the grace period. If You do not pay the required premiums by the end of the grace period, Your coverage will be cancelled.
    - We will provide You notice of Your nonpayment before cancelling Your Agreement. We will not pay for any services received on or after the date Your coverage ends.
- We demonstrate fraud or an intentional misrepresentation of material fact by an enrollee under the terms of the Agreement. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact may result in termination or rescission of this Agreement. This Agreement may also be terminated if You participate in or permit fraud or deception by any Provider, vendor, or any other person associated with this Agreement. Termination of Coverage will be effective on the date we mail the written notice of termination to You. Rescissions will be as the coverage effective date, and it will be as if You were never covered under this Agreement. We will provide You with a Notice of Rescission if we determine that fraud or an intentional misrepresentation has occurred.

Non-Renewal of Agreement
In the event We decide to discontinue the plan in which You are enrolled, We will provide You with a Notice of Non-Renewal at least ninety (90) days prior to termination of coverage.

Voluntary Termination
You are required to give at least fourteen days' notice if You would like to end coverage before the end of the contract term. You may give your notice of termination to Us or to Covered California, if applicable. If any premium has been paid for the time period following the requested date of termination and no claims have been submitted to Us for dates of service after the requested date of termination, we will refund or credit that premium within 30 days of the request for termination. In the case of retroactive terminations, we will not refund or credit any premium when claims have been submitted to Us for dates of service after the requested date of termination.

GUARANTEED RENEWABLE

Renewal Provisions
Coverage under this Agreement is guaranteed renewable except as permitted to be canceled, rescinded, or not renewed under applicable State and federal law, provided the Member is a qualified individual as determined by the Exchange. The Member may renew this Agreement by payment of the renewal Premium by the Premium due date, provided the following requirements are satisfied:

- Eligibility criteria as a qualified individual continues to be met;
- There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Agreement; and
- This Agreement has not been terminated by the Exchange.

REINSTATEMENT OF COVERAGE

If it is determined that cancellation, rescission or non-renewal of Your coverage was non-compliant with all legal requirements; or if Your coverage is terminated due to Non-Payment of Premium and You pay and We accept the outstanding premium amount, Your coverage will be reinstated. Reinstatement shall be retroactive to the time of cancellation, rescission, or failure to renew, and We shall be liable for expenses incurred by an enrollee for covered health care services from the date of cancellation, rescission, or non-renewal to and including the date of reinstatement. .

CONTINUATION

A Covered Person has the right to continue coverage if his or her eligibility under this Agreement would terminate due to:

- the Subscriber's death;
- divorce;
- no longer qualifying as a dependent under the Agreement; or
- if a Covered Person's eligibility for coverage under this Agreement terminates prior to that Covered Person being eligible for Medicare or Medicaid benefits.

Except in the event of divorce, the Agreement will be continued if the Covered Person notifies Us within 30 days following the date the Agreement would otherwise terminate, and pays the appropriate monthly premium. An Agreement shall be issued which provides benefits that are closest to, but not greater than, the terminated Agreement. Any probationary or waiting period set forth in the Agreement will be considered as met to the extent coverage was in force under the prior Agreement.

In the event of divorce, upon the entry of a valid decree of divorce between the Subscriber and Covered Spouse, the Spouse is entitled to have a Agreement issued to him or her within sixty days following the entry of the decree.

Section 12 – Grievances and Appeals

CULTURAL AND LINGUISTIC HANDLING OF GRIEVANCES 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, written translation and interpretation) that include answering questions in any applicable non-English language.
- Free aids and services such as qualified sign language interpreters and alternative written formats (audio, large print, or other formats)
- Assistance with filing claims and grievances 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 grievance process in a culturally and linguistically appropriate manner, in any County within our Service Area that has attained the threshold of 10% or more of the population being literate in the same non-English language as determined by the Department of Health and Human Services (HHS) and documented at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/clas-data.html.

WHAT TO DO IF YOU HAVE A QUESTION

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

DEFINED TERMS:

A “grievance” is a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee’s representative.

A “complaint” is the same thing as a “grievance”.

An appeal of an Adverse Determination, or denial, is a grievance.

WHAT TO DO IF YOU HAVE A GRIEVANCE OR COMPLAINT

You can submit your grievance the following ways:
Contact *Customer Service* at the telephone number listed in Section 2 of this Agreement and on Your ID card. *Customer Service* representatives are available to record your grievance over the phone, or You may submit a grievance in writing, if you prefer.

You may submit a written grievance to:

Bright HealthCare
P.O. Box 1519
Portland, ME 04104
Fax: 1-877-471-0295

You may also submit a grievance form online at www.brighthealthcare.com/individual-and-family/resource/member-resources.

You may also authorize someone to represent you. Authorization must be in writing. You may find a copy of the authorization form on the Bright HealthCare website at www.BrightHealthCare.com. Call Member Services for the authorization form at 1-844-476-3175. Your Member Services number is also on the back of your membership card. You have up to 180 calendar days from the date of an incident or dispute, or from the date the member receives a denial letter, to submit a grievance or appeal to Bright HealthCare.
Grievances received by Us will be acknowledged in writing within five (5) days. We will send You a confirmation letter within five (5) days after We receive Your grievance. After We have reviewed Your grievance, We will send You a written statement on its resolution or pending status.

Grievances involving determinations of medical necessity 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 grievance review, but may be called upon to answer questions regarding the initial Adverse Determination. The reviewer will consider all comments, documents, records, and other information You submit, without regard to whether the information was submitted or considered in making the initial Adverse Determination.

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

To submit a grievance regarding Your Mental Health and Substance Use Disorder benefits please contact Beacon Health Options of California:

By Mail: Beacon Health Options of California ATTN: Grievance Unit P.O. Box 6065 Cypress, CA 90630-0065
By Fax: (877) 635-4602
By Phone: (800) 228-1286 extension 262422 (a Quality Management Representative will assist you in completing the form)
By E-mail: CAComplaints@beaconhealthoptions.com
By Secure Web Site: www.beaconhealthoptionsca.com

To submit a grievance regarding Your dental benefits, please contact Liberty Dental Plan at:

LIBERTY Dental Plan
Grievances and Appeals
P.O. Box 26610
Santa Ana, CA 92799-6110
866-609-0426
TDD/TTY 711

Email: GandA@libertydentalplan.com
www.libertydentalplan.com/bhp
Fax: 833-250-1814

Notice of Grievance 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.

If You are dissatisfied with the resolution of Your grievance, or if Your grievance has not been resolved after at least thirty (30) days, You may submit Your grievance to the Department of Managed Health Care. For review prior to binding arbitration, see the Department of Managed Health Care section. If Your case involves an imminent and serious threat to Your health, as described in the Expedited Grievances section, You are not required to complete our grievance process, but may immediately submit Your grievance to the Department of Managed Health Care for review. You may at any time pursue Your ultimate remedy, which is binding arbitration. See the Independent Medical Review Process, and the Binding Arbitration sections in the proceeding pages.

EXPEDITED GRIEVANCES

Expedited Grievance Review Process

A grievance is expedited when a delay in decision-making may seriously jeopardize the life or health of a member or the member's ability to regain maximum function, including, but not limited to, severe pain, potential loss of life, limb, or when a member, subscriber, or group contract holder who believes their plan contract, enrollment or subscription has been or will be improperly cancelled, rescinded or not renewed.

An expedited grievance request does not need to be submitted in writing. An expedited review may be requested by calling us directly at the *Customer Service* number listed in Section 2 of this Agreement and on Your ID card. You may contact Us to file an expedited grievance 24 hours a day, 7 days a week.

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 grievance request.

Notice of Expedited Grievance Determination
You may bring expedited grievances directly to the Department of Managed Health Care (DMHC). We will make a decision and notify You and/or Your designated representative, Your Physician, and the Department of Managed Health Care as expeditiously as possible. Our initial notification will be by telephone, fax, or electronic means. In no case will our initial notification be provided more than 72 hours after Our receipt of the expedited grievance request or the information necessary to make a determination.

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

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

DEPARTMENT OF MANAGED HEALTH CARE COMPLAINTS

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (844) 926-4524 and use your health plan s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department s Internet Web site http://www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

INDEPENDENT MEDICAL REVIEW PROCESS

After You have gone through the internal grievance process, You may request an Independent Medical Review from the Department of Managed Health Care (DMHC). There is no cost to You if you choose to request an IMR. You have the right to provide information in support of the request for IMR. We are required to provide You with an IMR application form with any appeal disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause You to forfeit any statutory right to pursue legal action against Us regarding the disputed health care service.

Eligibility
The DMHC will review Your application for IMR to confirm that:

- At least one of the following has occurred:
  - Your provider has recommended a health care service as Medically Necessary, or
  - You have received Urgent Care or Emergency Services that a provider determined was Medically Necessary, or
  - You have been seen by an Network Provider for the diagnosis or treatment of the medical condition for which You seek independent review;
- The disputed health care service has been denied, modified, or delayed based in whole or in part on a decision that the health care service is not Medically Necessary; and
- You have filed a Grievance with Us and the disputed decision is upheld or the Grievance remains unresolved after thirty (30) days. If Your Grievance requires expedited review You may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that You follow Our Grievance process in extraordinary and compelling cases.

If Your case is eligible for IMR, the dispute will be submitted to a medical Specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made

in Your case. If the IMR determines the service is Medically Necessary, We will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within thirty (30) days of receipt of Your application and supporting documents. For urgent cases involving an imminent and serious threat to Your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health, the IMR organization must provide its determination within three (3) business days.

For more information regarding the IMR process, or to request an application form, please call Us at the telephone number listed in Section 2 of this Agreement and on Your ID card.

BINDING ARBITRATION – AGREEMENT TO RESOLVE ALL DISPUTES, INCLUDING FUTURE MALPRACTICE CLAIM BY BINDING ARBITRATION

All disputes including but not limited to disputes relating to the delivery of services under the Agreement or any other issues related to the Agreement and claims of medical malpractice must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of small claims court and the dispute can be submitted to binding arbitration under applicable federal and state law, including but not limited to, the Patient Protection and Affordable Care Act. It is understood that any dispute including disputes relating to the delivery of services under the plan or any other issues related to the plan, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

You and Bright HealthCare agree to be bound by this arbitration provision and acknowledge that the right to a jury trial or to participate in a class action is waived for both disputes relating to the delivery of service under the Agreement or any other issues related to the Agreement and medical malpractice claims.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION section. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The arbitration findings will be final and binding except to the extent that State or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the Member making a written demand on Bright HealthCare. The arbitration will be conducted by a single neutral arbitrator from Judicial Arbitration and Mediation Services (“JAMS”), according to JAMS’ applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by a single neutral arbitrator from another neutral arbitration entity, by Agreement of the Member and Bright HealthCare, or by order of the court, if the Member and Bright HealthCare cannot agree. If the parties cannot agree on the individual neutral arbitrator, the arbitrator will be selected in accordance with JAMS Rule 15 (or any successor rule).

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. Unless You and Bright HealthCare agree otherwise, the arbitrator may not consolidate more than one person's claims, and may not otherwise preside over any form of a representative or class proceeding. In cases of extreme hardship, Bright HealthCare will assume some of the Member’s or Subscriber’s share of the fees and expenses of the arbitrator.

Please send all binding arbitration demands in writing to:

Bright HealthCare
219 N. 2nd Street, Suite 401
Minneapolis, MN 55401

Section 13 - Information on Agreement and Rate Changes

CHANGES TO THIS AGREEMENT

We may change Your *Agreement* by adding Amendments. Amendments are legal documents that change certain parts of the Agreement. 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 Agreement depends on who is covered by the Agreement. If You change who is covered under the Agreement, 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 notify You at least 60 days in advance of a change to Your premium.

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 AGREEMENT

If You do not take action to cancel or change Your plan or if we have not been otherwise notified, Your Agreement 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.

OTHER COVERAGE OFFERED BY THIS HEALTH PLAN

If while covered under this Agreement, You are also covered by another individual Agreement issued by Us, You be entitled to the benefits of only one Agreement. You may choose this Agreement or the Agreement under which You will be covered. We will then refund any premium received under the other Agreement covering the time period both policies were in effect.

However, any claims payments made by Us under the Agreement You elect to cancel will be deducted from any such refund of premium.