Bright HealthCare™

2023
Certificate of Coverage

BrightHealthCare.com

SECTION 1 – TITLE PAGE (COVER PAGE)
INDIVIDUAL EVIDENCE OF COVERAGE ("EOC")

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

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

Entire Contract

This EOC includes Your:

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

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

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

How To Use This Document

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

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

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

Right To Cancel Or Return This EOC

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

Information About Defined Terms

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

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

BRIGHT HEALTH
Toll Free – (844)926-4524
P.O. Box 1357
Portland, ME 04104
www.brighthealthcare.com

Michael Carson
Chief Executive Officer

Have A Complaint Or Need Help?

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

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

Bright HealthCare Insurance Company of Texas
To get information or file a complaint with your insurance company or HMO: Call:
Member Services Toll-free at: (844) 926 -4524
Online: www.brighthealthcare.com
Mail: P.O. Box 1357, Portland, ME 04104

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state: Call
with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

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

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

Bright HealthCare Insurance Company of Texas
Para obtener información o para presentar una queja ante su compañía de seguros o
Llame a: Memberal (844) 926-4524Teléfono gratuito: (844) 926-4523
En línea: www.brighthealthcare.com
Dirección postal:P.O. Box1357
Portland, ME 04104

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

This Is A Health Maintenance Organization ("HMO") Plan

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

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

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

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

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

SECTION 2 – CONTACT US

Please contact Us for more information.

Questions About Your Benefits

Member Service:	On Our Website at:
(844)926-4524	www.brighthealthcare.com
TTY: 711	

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

Bright Health Plan
P.O. Box 1357
Portland, ME 04104

Nondiscrimination Notice and Assistance with Communication

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

Language Assistance and Alternate Formats

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

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

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

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

Bright Health Civil Rights Coordinator Bright Health Care
P.O. Box 1519
Portland, ME 04104
Phone: (844) 926-4524

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

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

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

Member Rights And Responsibilities

You Have the Right to:

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

You Have the Responsibility to:

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

- Pay all Copayments, Annual Deductibles and Percentage Copayment for which You are responsible, at the time service is rendered or when they are due.
- Keep scheduled appointments and notify the health care professional's office ahead of time if You are going to be late or miss an appointment.
- Pay all charges for missed appointments and for services that are not covered by Your plan.
- Voice Your opinions, concerns, or complaints to Our Member Services 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.

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

English	ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call the Member Services number on your ID card.
Arabic	انتباه: إذا كنت تتحدث لغة غير الإنجليزية، فخدمات المساعدة اللغوية متاحة من أجلك، دون تكلفة. اتصل برقم خدمات الأعضاء الموجود على بطاقة تعريف الهوية الخاصة بك.
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。请拨打身份证上的会员服务号码。
French	ATTENTION : Si vous parlez une autre langue que l'anglais, des services d'assistance linguistique sont mis gratuitement à votre disposition. Appelez le numéro des services aux membres figurant sur votre carte d'identification.
German	ACHTUNG: Falls Sie eine andere Sprache als Englisch sprechen, steht Ihnen eine kostenfreie fremdsprachliche Unterstützung zur Verfügung. Wählen Sie die Mitgliederservice-Nummer auf Ihrer ID-Karte.
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε κάποια γλώσσα διαφορετική από τα Αγγλικά, παρέχονται δωρεάν υπηρεσίες γλωσσικής βοήθειας. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card).
Italian	ATTENZIONE: se parla una lingua diversa dall'inglese, sono disponibili servizi di assistenza linguistica gratuiti. Chiami il numero Member Services che trova sulla Sua tessera identificativa.
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。IDカードに記載されているメンバーサービスの番号までお電話ください。
Korean	주의: 영어가 아닌 다른 언어를 사용할 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 신분증에 기재된 회원 서비스 번호로 연락하십시오.
Polish	UWAGA: Jeśli nie mówisz po angielsku, możesz skorzystać z darmowych usług tłumaczeniowych. Zadzwoń na numer obsługi podany na twojej karcie identyfikacyjnej.
Portuguese	ATENÇÃO: Se falar um idioma que não o inglês, estão disponíveis serviços gratuitos de assistência de idioma para si. Contacte o número de serviços para membros no seu cartão de identificação.
Russian	ВНИМАНИЕ: если вы не говорите на английском языке, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните в Отдел обслуживания участников программы по телефону, указанному на вашей идентификационной карточке.
Spanish (US)	ATENCIÓN: Si no habla inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Comuníquese al número de Servicios para miembros que figura en su tajeta de ID.
Tagalog	PAALALA: Kung nagsasalita ka ng isang wika bukod sa Ingles, magagamit mo ang mga serbisyong tulong sa wika nang walang bayad. Tumawag sa numero ng Member Services na nasa iyong ID card.

Urdu

توجہ دیں: اگر آپ انگریزی کے علاوہ کوئی اور زبان بولتے ہیں تو آپ کیلئے زبان کی معاونت کی خدمات مفت دستیاب ہیں۔ اپنے ID کارڈ پر موجود اراکین کی خدمات کے نمبر 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 Dịch vụ Hội viên trên Thẻ ID của bạn.

Navajo

Shooh: Bilagáanaa bizaad doo doohts'a'góó, ata'hane', t'áá níík'eh, níká'adoojahígíí hóló. Naaltsoos bee éédahózin bikáá' béésh bee hane' biká'ígíí bich'į' hodíílnih.

Amharic

ማሳሰቢያ: ከእንግሊዝኛ ውጪ የሆነ ቋንቋ የሚናገሩ ከሆነ ከክፍያ ነጻ የሆኑ የቋንቋ ድጋፍ አገልግሎቶችን ማግኘት ይችላሉ:: በመታወቂያ ላይ በሚገኝ የአባላት አገልግሎት ቁጥር ላይ ይደውሉ::

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե Դուք խոսում եք բացի անգլերենից այլ լեզվով, Դուք կարող եք անվճար օգտվել թարգմանչական ծառայություններից: Զանգահարեք անդամների սպասարկման ծառայություն, որը նշված է ձեր ID-ում:

Burmese

သင်သည် အင်္ဂလိပ်စကားမဟုတ်သော အခြားဘာသာစကားတစ်ခုအား ပြောဆိုသူဖြစ်ပါက ဘာသာစကားအခမဲ့ပံ့ပိုးသည့် ဝန်ဆောင်မှုအား သင်ရရှိနိုင်ပါသည်။ သင့် ID (သက်သေခံ) ကတ်ပြားပေါ်ရှိ အဖွဲ့ဝင်များဝန်ဆောင်မှုဌာနအား ဖုန်းခေါ်ဆိုပါ။

Cherokee

ᏧᏬᏎᏍᏓᏓ: ᏱᎢ ᏕᏬᏂᏍᎩ ᏯᏬᏂᏧ ᏏᏃ ᎩᎵᏏ, ᏕᏬᏂᎯᏍᏗ ᎠᎵᏍᏚᎵᏍᎩ ᎢᏗᏝᏛᏁᏗᎢ, Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏯᎩ ᎠᏎᎳᎢ, ᏂᎯ ᎡᏩᏛᏬᎢᏍᏓᏁᏘᎢ. ᎾᏍᎩᏃ ᏜᏚᎾ ᏪᎵ ᎠᎵᏍᏚᎵᏍᎩ ᏗᏎᏍᏗ ᎤᎾᎢ ᏩᏙᎵ ᎪᏟᏍᏛᏗ ᏆᎾᏲᏍᏗ.

Cushite-Oromo

XIYYEEFFANNOO: Afaan Ingiliziin ala afaan kan biraa kan dubbattu yoo ta'e, tajaajilliwwan gargaarsa afaanii, kan tolaa, siif ni jiru. Kaardii Waraqaa-eenyummeessaa keerra kan jiru lakkoofsa Tajaajilawwan Miseensaatti bilbili.

French Creole

ATANSYON : Si w pale yon lòt lang ke Angle, gen sèvis èd lengwistik ki disponib pou w gratis. Rele nimewo Sèvis pou manm yo nan kat idantite w la.

Gujarti

ધ્યાન આપો: જો તમે અંગ્રેજી સિવાયની અન્ય કોઈ ભાષા બોલો છો, તો તમારા માટે ભાષા સહાય સેવાઓ નિ:શુલ્ક ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર રહેલા સદસ્યની સેવાઓનાં નંબર પર કૉલ કરો.

Hindi

ध्यान दें: यदि आप अंग्रेजी के अलावा कोई अन्य भाषा बोलते हैं, तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। आपके आईडी कार्ड पर दिए गए सदस्य सेवा नंबर पर कॉल करें।

Hmong

UA ZOO SAIB: Yog tias koj hais ib hom lus dhau ntawm lus As Kiv, muaj cov kev pab cuam txhais lus uas tsis xam nqi dab tsi rau koj tau siv. Hu rau Lub Chaw Pab Cuam Tswv Cuab tus nab npawb xov tooj nyob ntawm koj daim npav ID.

Karen

တၢ်နီၣ်/–/နမ့ၢ်ကတိၤကျိာ်လၢတမ့ၢ်အဲကလံးကျိာ်ဘၣ်နူၣ်,/ကျိာ်တၢ်တိစၢၤမၤစၢၤတၢ်မၤစၢၤတဖၣ်,/လၢတလိၣ်ဟ့ၣ်အပ့ၤတဖၣ်အိၣ်လၢနဂီၢ်နူၣ်လီၤ./ကိးကရၢဖိတၢ်မၤစၢၤတဖၣ်/(နနာ်ဘနမ့ နမလၢငခ္ဍ)/ အနီၣ်ဂံၢ်ဖဲန/တၢ်ဆှၣ်သးနီၣ်ဂံၢ်ခးက့ အဖီခိၣ်နူၣ် တက့ၢ်.

Kru / Bassa

YI LE: I balè u mpot hop umpè èbes Ngissi, bot ba nhola ni kobol mahop bayé ha i nyuu yoñ, ngui nsaa wogui wo. Sebel Ndap Mahola i nyuu Mbon i nsinga i yé ntilgaga munu i Kat yon i Mbon.

Kurdish

ئاگاداری: ئەگەر بە زمانێکی تری جگە لە ئینگلیزی قسە دەکەیت، خزمەتگوزاریە زمانەوانیەکان بەخۆرایی بۆ تۆ بەردەستن. پەیوەندی بە ژمارەی خزمەتگوزاری ئەندامانی سەر ناسنامەکەت بکە.

Laotian

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາອື່ນນອກຈາກພາສາອັງກິດ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາທີ່ບໍ່ເສຍຄ່າແມ່ນມີພ້ອມໃຫ້ທ່ານ. ກະລຸນາໂທຫາ ໝາຍເລກການບໍລິການສະມາຊິກທີ່ຢູ່ເທິງ ບັດ ID ຂອງທ່ານ.

Mon-Khmer	ចាប់អារម្មណ៍៖ ប្រសិនបើលោកអ្នកនិយាយភាសាផ្សេង ក្រៅពីភាសាអង់គ្លេស នោះសេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសម្រាប់លោកអ្នក។ សូមទូរស័ព្ទទៅលេខសេវាបម្រើសមាជិកដែលមាននៅលើកាតសម្គាល់របស់លោកអ្នក។
Nepali	ध्यान दिनुहोस्: यदि तपाइँ अङ्ग्रेजी बाहेक अन्य भाषा बोल्नुहुन्छ भने तपाइँको लागि निःशुल्क रूपमा भाषा सहायता सेवा उपलब्ध छ। तपाइँको आइडी कार्डमा भएको सदस्य सेवा नम्बरमा कल गर्नुहोस्।
Persian Farsi	توجه: در صورتی که به زبانی غیر از انگلیسی صحبت می کنید خدمات کمکی زبانی به طور رایگان برای شما وجود دارد. برای این منظور با شماره خدمات اعضای موجود روی کارت شناسایی خود تماس بگیرید
Serbo-Croatian	PAŽNJA: Ako govorite neki drugi jezik osim engleskog, dostupne su vam besplatne usluge za jezičnu pomoć. Pozovite broj službe za članove na vašoj ličnoj karti.
Syriac	ܙܘܗܪܐ: ܐܢ ܗܘ ܕܡܡܠܠܬ ܐܝܠܗ ܠܫܢܐ ܐܚܪܢܐ ܣܛܪ ܡܢ ܠܫܢܐ ܐܢܓܠܝܐ: ܗܘ ܐܠܟܘܢ ܚܠܡܬܐ ܕܡܥܕܪܢܘܬܐ ܕܠܫܢܐ ܕܠܐ ܡܓܢܐܝܬ. ܘܠܐ ܡܨܝܐ ܠܟܘܢ ܡܚܒܪܘܢ ܒܢܘܡܪܐ ܕܫܡܫܝܢ ܘܡܚܒܪܢܐ ܘܫܡܫܘܬܐ ܕܠܫܢܐ (Member Services)
Thai	ข้อควรทราบ: หากคุณใช้ภาษาอื่นที่ไม่ใช่ภาษาอังกฤษ เรามีบริการความช่วยเหลือทางภาษาจัดให้แก่คุณโดยไม่คิดค่าใช้จ่ายใด ๆ ติดต่อหมายเลขให้บริการสมาชิกที่บัตรประจำตัวของคุณ
Turkish	DİKKAT: İngilizce haricinde bir dil konuşuyorsanız, dil yardım hizmetlerinden ücretsiz olarak faydalanabilirsiniz. Kimlik kartınızın üzerindeki numaradan Üye Hizmetlerini arayın.
Ukrainian	УВАГА: якщо ви не розмовляєте англійською, то можете скористатися безкоштовними послугами мовної підтримки. Зателефонуйте до Відділу обслуговування учасників програми за телефоном, вказаним на вашій ідентифікаційній картці.

SECTION 3 – TABLE OF CONTENTS

SECTION 4 – ELIGIBILITY

We offer the following types of coverage:

- Individual. If You selected individual coverage, then You are covered.
- Individual and Spouse. If You selected individual and Spouse coverage, then You and Your Spouse are covered.
- Individual and Child(ren). If You selected individual and child(ren) coverage, then:
  - You and Your Dependent Child(ren), are covered;
- Family. If You selected Family Coverage, then You, Your Spouse and Your Dependent Child(ren) are covered.
- Child-only. If a child under 18 years of age needs coverage, then the child may enroll in his or her own Plan with a Responsible Adult. A Responsible Adult must be 18 years old or older and is not covered under the child's Plan. The Responsible Adult is responsible for payment of Premium. Child(ren) subject to a valid support order requiring health benefit coverage will be covered, whether or not there is an adult who will be provided coverage.

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

Who Is Eligible For Coverage

Eligible Subscribers

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

- Reside, live, or work in the Service Area (if You or an enrolled Dependent reside outside the Service Area and incur health care services, You may be subject to higher Out-of- Pocket expenses, except that an enrolled Dependent whose coverage by a Subscriber is required by a medical or dental support order, will receive coverage comparable to other Dependents covered by this EOC).
- Not be enrolled in Medicare Parts A, B and/or D on Your Effective Date of coverage with Us. It is unlawful for Us to knowingly issue an individual market EOC to You if You are enrolled in Medicare on Your Effective Date. If we have knowledge of Your enrollment in Medicare, we will not issue a EOC to You.

Eligible Dependents

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

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

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

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

When Coverage Begins

If you are a new Covered Person with Bright Health and have paid your first month's premium, your coverage will begin on the date listed as the Effective Date on Your ID Card. No health services received prior to the Effective Date are covered.

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

Open Enrollment Period

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

Special Enrollment Period

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

Enrolling Eligible Dependents

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

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

• A court orders that You cover a current spouse or minor child onto Your EOC;
• An individual gains a Dependent or becomes a Dependent through marriage, civil union, birth, adoption, or placement for adoption, placement for foster care, through a child support order or other court order, or by entering into a Designated Beneficiary agreement. In the case of marriage, at least one spouse must demonstrate having minimum essential coverage for one or more days during the 60 days preceding the date of marriage.
• An individual gains access to other Creditable Coverage as a result of a permanent change of residence; or
• A parent or legal guardian dis-enrolling a Dependent, or a Dependent becoming ineligible for Medicaid or an S-CHIP plan;
• An individual becoming ineligible under Medicaid or the state's Medical Assistance Program for the medically needy;
• An individual Loses pregnancy related coverage or loses access to health care services through coverage to a pregnant woman's unborn child. The date of loss of coverage is the last day the qualified individual would have pregnancy related coverage or access to health care services through the unborn child coverage.
• A qualified individual who is or becomes a dependent of an Indian, as defined by section 4 of the Indian Health Care Improvement Act and is enrolled or in enrolling in a Qualified Health Plan through an Exchange on the same application as the Indian, may change from one Qualified Health Plan to another one time per month, at the same time as the Indian;
• The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by state law, or if the Enrollee, or his or her dependent, dies;
• 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 who is newly released from incarceration.
• An individual's enrollment or non-enrollment in a health benefit plan is unintentional, inadvertent, or erroneous and is the result of an error, misrepresentation, or inaction of the carrier, producer, or Exchange;
• An individual or enrollee: -is a victim of Domestic Abuse or spousal abandonment, including a Dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or -is a Dependent of a victim of Domestic Abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;

• An individual or dependent:-applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event; or-applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;
• A qualified individual or his or her dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for advance payments of the premium tax credit based in part on a finding that 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.
• An individual Is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if the individual or his or her dependent has the option to renew the coverage. The date of loss is the last day of the plan or EOC year.
• An individual becomes newly eligible for enrollment in a Qualified Health Plan through the Exchange because he or she newly satisfies the requirements.
• An individual or Dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the decision to purchase a plan through the Exchange; or
• At the option of the Exchange, the individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Exchange following termination of Exchange enrollment due to a failure to verify such status within a specified time period or is under 100 percent of the Federal poverty level and did not enroll in coverage while waiting for verification of citizenship, status as a national, or lawful presence. • At the option of the Exchange, an individual qualifies for a low-income Special Enrollment Period through the Exchange
• An individual adequately demonstrates to the commissioner that the Health Benefit Plan in which the individual is enrolled has substantially violated a material provision of its contract in relation to the individual;
• A qualified individual or enrollee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide, including being incapacitated or experiencing a natural disaster;
• Any other event or circumstance occurs as set forth in rules from the State 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.

Enrollment of Newly Eligible Dependent

A Subscriber must submit an Enrollment Application requesting coverage for Dependents who become eligible after the original EOC Effective Date. The Subscriber will be notified of coverage approval, the amount of required Premium payment, and the Effective Date of coverage for the Dependent.

A dependent newborn child is automatically covered for the first 31 days of life. If you wish to continue enrollment of the newborn beyond the 31st day, the newborn must meet the definition of an eligible Child, and you must enroll the newborn within 60 days of the date of birth. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber is required to pay the full premium responsibility for the newborn after the initial 31 days of coverage.

For newly adopted children (including children newly placed for adoption), the Effective Date of coverage is the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 60 days from the date the child is placed in Your custody or the date of the final decree of adoption. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber is required to pay the full premium responsibility for the adopted child. The monthly premium for the newly adopted child is the entire month's premium. Adopted child premiums are not pro-rated.

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

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

Change In Status – Notice Required

The Subscriber is responsible for notifying Us or the Exchange of any changes that affect eligibility for services under this EOC. Changes may be on the Subscriber's or enrolled Dependent's eligibility. The Subscriber must notify Us or the Exchange within 60 days of the event. This includes changes of address, addition or deletion of dependents resulting from death, achieving the limiting age, and changes in Dependent Disability or Dependent status. Coverage for ineligible members will terminate in accordance with the termination provisions described in this EOC.

SECTION 5 – HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

Benefits under this plan are limited to those Covered Health Services included in the *Benefits/Coverages (What is Covered*) section of this document. Benefits are reimbursable as set forth in the Schedule of Benefits. Benefits are provided through contracts with Network Providers, who agree to hold Subscribers harmless for payment of the cost of covered health care services beyond those listed in the Schedule of Benefits. All Covered Health Services are subject to the limitations and exclusions contained in the *Limitations/Exclusions (What is Not Covered)* Section of this EOC.

This Is A Network-Only Plan

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

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

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

Choose Your Physician

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

Participating Providers are listed on Our website at ***www.brighthealthcare.com*** or You can contact Member Services at the telephone number listed in *Section 2* of this *EOC* and on Your ID card to obtain a copy of Our Provider Directory.

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

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

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

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

This plan allows You to:

- Choose from Our Network of Participating Providers and Hospitals for Your health care needs;
- Have direct access to eye care providers, mental health care providers, pediatricians, obstetrical or gynecological health care professionals. You do not need Prior-Authorization from the plan or from any other person (including a primary care provider) in order to obtain access to mental health, obstetrical, or gynecological care from a health care professional in Our network who specializes in those types of

services. The health care professional, however, may be required to comply with certain provisions related to 1) obtaining Prior -Authorization 2) following a pre-approved treatment plan, and 3) following procedures for making referrals to other Participating Providers. For a list of participating health care professionals who specialize in eye care, mental health, and obstetrics or gynecology, visit Our website at www.brighthealthcare.com or call Our Member Services line at the number listed in Section 2of this EOC and on Your ID card. Take advantage of significant cost savings when You use doctors contracted with Us.

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

If you have a chronic, disabling or life-threatening illness, You can request to use a Network Specialist as your PCP. Your Network Specialist must let Us know that they agree to act as Your PCP. You can contact Member Services at the number on the back of Your ID card for information about applying for this exception.

Transition Of Care (When You Are A New Member)

You may be eligible for the Transition of Care process when You are a new member of Our plan and wish to continue receiving care from a Non-Network Provider. The Transition of Care process facilitates continuation of services for specific acute or complex medical and behavioral conditions with Non-Network doctors, Hospitals, and Providers for a defined period of time, until Your care is safely transferred.

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

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

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

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

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

For information on how to apply for Transition of Care, contact Member Services at the telephone number listed in the *Contact Us* section of this EOC and on Your ID Card.

Continuity Of Care (When Your Provider Leaves Our Network)

You may be eligible for the Continuity of Care process when Your Provider leaves Our network and You wish to continue to receive services from that Provider. The Continuity of Care process facilitates continuation of services at In-Network coverage levels for specified medical and behavioral conditions for a defined period of time when your In-Network doctor, hospital, or Provider leaves our Network and there are reasons preventing immediate transfer of care to another Network Provider that they reasonably believe could cause harm to you. Your Provider should notify Us of the request for Continuity of Care within 30 days of your Network Provider leaving our Network.

If you are under the care of a Network Provider at the time such Provider stops participating in the Network and at the time of the Network Provider's termination, the Covered Person has special circumstances. Special

circumstances" means a condition such that the treating physician or health care provider reasonably believes that discontinuing care could cause harm to the patient. Special circumstances shall be identified by the treating physician or health care provider, who must request that the patient be permitted to continue treatment under the physician's or provider's care and agree not to seek payment from the patient of any amounts for which the patient would not be responsible if the physician or provider were still an In-Network Provider. Special circumstances include a (1) disability, (2) acute condition, (3) life-threatening illness, or (4) when a person is pregnant and undergoing a course of treatment for the pregnancy or is past the 24th week of pregnancy at the time the Provider leaves Our Network, in which case the member is eligible for this provision through the delivery and post-partum care within the six (6) week period following delivery, (5) when a person is undergoing a course of treatment for a serious and complex condition from the provider or facility, (6) is undergoing a in accordance with the dictates of medical prudence , (7) is undergoing a course of institutional or Inpatient care from the Provider or Facility, (8) is scheduled to undergo non-elective surgery from the Provider, including receipt of postoperative care from such Provider or Facility with respect to such surgery. We will continue providing coverage for that Provider's services at the In-Network benefit level.

The continuity of coverage under this subsection will not extend for more than ninety (90) days, except as required by state law

For information on how to apply for Continuity of Care, contact Bright Health Plan Member Services at the telephone number listed in *Section 2 of this EOC and on Your ID card*.

You can obtain a listing of Network Providers on Our website, or by contacting the Member Services Department at the telephone number listed in Section 2 of this EOC and on Your ID card. The provider's Network status is subject to change, so always confirm the provider's Network status he 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. To review these policies, contact Member Services at the telephone number listed in the Contact Us section and on Your ID Card.

Receiving Non-Emergent Care From Non-Network Providers

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

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

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

These Non-Network Providers may send You a balance-bill, which is a bill for the difference between the amount We pay the provider and the provider's billed charges. If You receive a balance-bill You should contact Us at (855) 827-4448. You may also contact the Consumer Protection Division of the Texas Department of Insurance at (800) 252-3439 with complaints regarding payment.

Non-emergent services from Non-Network Providers are also covered by the Plan when Medically Necessary Covered Health Care Services are not available through a Network Provider. We will authorize a referral to a Non-Network provider, upon the request of a Network Provider and within a reasonable period (not to exceed 5 business days) after receipt of reasonably requested documentation. The Non-Network Provider will be reimbursed at the usual and customary rate or at an agreed rate. Any such request for a referral will be reviewed by a provider of the same or similar specialty as the Non-Network Provider to whom a referral is requested. Failure to obtain authorization from Us of a referral to a Non-Network Provider prior to receiving services from a Non-Network Provider will result in such services not being covered under this Plan.

Receiving Emergency Care From Network Providers Or Network Facilities

When receiving Medically Necessary Emergency Health Services from a Participating or In-Network facility, You will be responsible for Your In-Network Copayment or Percentage Copayment amounts as indicated in Your Schedule of Benefits.

Receiving Emergency Care From Non-Network Providers Or Non-Network Facilities

When receiving emergency care that qualifies as Emergency Health Services from a Non-Network Provider in a Non-Network facility, payment from the Plan, unless otherwise permitted by law, will be the greater of:

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

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

Prior Authorized Care From Non-Network Providers

In a case where We do not have a Network Provider or Specialist within Our network to provide services for a covered Benefit, We may issue Prior Authorization to see a Non-Network Provider.

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

Payment For Charges To Non-Network Providers

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

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

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

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

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

Our Reimbursement Policies

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

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

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

Network Providers are contractually obligated to follow Our reimbursement policies and may not bill You for any balances other than Your Copayment, Deductible or Coinsurance amounts after the Provider receives payment from Us.

Services provided by a Non-Network Provider at a Network facility will be reimbursed according to 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.

Limitations On Selection Of Providers

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

Service Area

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

Your Service Area Includes:

Counties
Brazoria, Collins, Dallas, Denton, Fort Bend, Galveston, Harris, Hays, Montgomery, Parker, Tarrant, Travis, and Williamson.

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

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

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 Member Services Department at the telephone number listed in Section 2 of this EOC and on Your ID card for assistance.

Medical Necessity

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

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

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

- It is known to be effective in improving health outcomes

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

- For new interventions, effectiveness is determined by scientific evidence
- For existing interventions, effectiveness is determined by:
  - Scientific evidence
  - Medical literature, and other evidence-based guidelines
  - Professional organization practice guidelines
  - Expert opinion, and
  - Consideration of cost-effectiveness compared to alternative interventions, including no intervention which, includes consideration of the appropriate methods, manners, supplies, as well as setting where services are received
  - State and federal regulatory agencies
  - Technology assessment information services
  - If the requested service is considered investigational or experimental

Second Opinions

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

Prior-Authorization

Prior-Authorization is the process of reviewing a request for health care services prior to receiving care. Prior-Authorization may be required to make sure services are Medically Necessary, . Please refer to Your *Schedule of Benefits* to see which services require Prior-Authorization. This information can also be obtained by visiting our website: www.brighthealthcare.com

The Provider is In-Network. Please refer to Your *Schedule of Benefits* to see which service require Prior-Authorization.

Who is responsible for obtaining Prior-Authorization?

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

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

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

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

Failure to obtain the Prior-Authorization prior to receiving care may result in services not being covered.

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

- 1 hour for requests involving post-stabilization treatment or a life-threatening condition;
- 24 hours for requests involving concurrent hospitalization care or a Covered Person who is inpatient in

a health care facility at the time the services are proposed;
- 3 calendar days for all other requests.

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

If You do not obtain the necessary Prior-Authorization prior to receiving 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.

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

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

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

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

Decide What Services You Should Receive
Care decisions are between You and Your health care provider. We do not make decisions about the kind of care You should or should not receive. We make determinations of benefits according to Medical Necessity, the provider's or facility's network status, and whether or not the service(s) are a Covered Health Service under Your plan.

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

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

Your Copayments may not exceed 200 percent of Your annual premium or 50 percent of total costs of service in any calendar year. *Refer to the Schedule of Benefits (Who Pays What)* section of this EOC 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/Percentage Copayment is the percentage of any Allowable Amount that You are required to pay for certain Covered Health Services. Percentage Copayment amounts accumulate towards Your Out-of-Pocket Maximum.

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

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

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

For EOCs that provide coverage to two or more people, each Covered Person's Individual Out-of-Pocket Maximum applies to the Family Out-of-Pocket Maximum. Once a Covered Person has met his or her Out-of-Pocket Maximum, the Covered Person will have no further obligation to pay charges for in-Network Covered Health Services for the remainder of the Calendar Year. Once two or more Covered Person's combined Out-of-Pocket expenses reach the Family Out-of-Pocket Maximum, Covered Persons under the Family EOC will have no further obligation to pay charges for in-Network Covered Health Services.

Premium amounts, balance-billing charges and penalty amounts do not apply to Your Out-of-Pocket Maximum.

SECTION 6 – BENEFITS/COVERAGE (WHAT IS COVERED)

Benefit Determinations

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service You receive. Our decisions are for payment purposes only. We do not make decisions about the kind of care You should or should not receive. You and Your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations, and exclusions set out in this EOC which includes the Schedule of Benefits and any Amendments.
- Make factual determinations related to Benefits.

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

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

Explanation Of Covered Health Services

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

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

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

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

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

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

Covered Health Services

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

Accidental Injury Dental Services

Outpatient Services, physician Home Visits and Office Services, Emergency Care and Urgent Care services received at an Urgent Care Center for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely

affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

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

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

Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least50% bony support, and are functional in the arch.

Acquired Brain Injury

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

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

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

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

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

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

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

Allergy Testing and Treatment

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

Ambulance Services/Emergency Transportation

Covered Health Services under this section include:

- Emergency ground or air ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.
- Non-Emergency ambulance transportation when Prior Authorized and offered by a licensed ambulance service (either ground, water, or air ambulance) between facilities **only** when the transport is a result of any of the following:
- Transfer from a Non-Network Hospital/facility to a Network Hospital/facility
- Transfer to a Hospital that provides a higher level of care than was available at the original

Hospital/facility
- Transfer to a more cost-effective acute care facility
- Transfer from a facility to the home
- Transfer from an acute facility to a sub-acute facility/setting

If You access Ambulance services for non-emergency Health Services and You did not have Prior Authorization from Us, the services will not be covered. You will be responsible for the entire amount that the Provider bills.

Non-emergent air transportation requires Pre-Authorization.

Amino Acid-Based Elemental Formulas
Covered Health Services include formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:
- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins.
- Severe food protein-induced enterocolitis syndromes;
- Eosinophilic disorders, as evidenced by the results of biopsy; and
- Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

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

Autism Spectrum Disorders (ASD)
Services covered under this section include assessment, diagnosis and treatment of Autism Spectrum Disorders Including, including outpatient therapy services and Applied Behavioral Analysis and as required by state law and subject to state age and dollar limits, where applicable.

Some services for the treatment for Autism Spectrum Disorder may require Prior-Authorization by the Plan.

Outpatient Therapy Services for Autism Spectrum Disorder are subject to the plan's annual limitations for such services, if applicable. Refer to the Outpatient Therapy Services section of this document and/or Your Schedule of Benefits.

Breastfeeding Support, Services and Supplies
Services for breastfeeding counseling and support are covered when rendered by a Provider during pregnancy and/or in the post-partum period. Benefits include up to a 12-month rental (or the purchase if more cost effective) of manual breast pumps, accessories and supplies. You may be required to pay the full amount and submit a claim form to Us with the itemized receipt for the breast pump, accessories and supplies. Visit the Member Hub to obtain a claim form.

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

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

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

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

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

Services are limited to 35 visits per calendar year, combined with outpatient habilitation and rehabilitation therapies.

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

Chiropractic services are available through our chiropractic vendor. Please refer to Our website at https://brighthealthcare.com/search?lob=hasifp to find a chiropractor in your area.

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

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

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

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

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

The coverage is subject to all terms and conditions of this EOC. The coverage does not include:

- Any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry
- Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device
- The cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration;
- Costs of services that (A) are inconsistent with widely accepted and established regional or national

standards of care for a particular diagnosis, or (B) are performed specifically to meet the requirements of the Clinical Trial;

- Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing, and other expenses that the Covered Person or person accompanying the Covered Person may incur
- An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the Covered Person
- Costs for the management of research relating to the clinical trial or study; or
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the Covered Person's health plan
- After the clinical trial ends, coverage is not provided for non-FDA approved drugs that were provided or made available to an enrollee during a covered clinical trial.

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

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

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

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

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

"Routine patient care cost" means the costs of any Medically Necessary health care service for which benefits are provided under a health benefit plan, without regard to whether the enrollee is participating in a clinical trial. : Routine patient care costs do not include:

- the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
- the cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
- the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- a cost associated with managing a clinical trial;
- the cost of a health care service that is specifically excluded from coverage under a health benefit plan.

Congenital Defect and Birth Abnormalities

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

Rehabilitation Outpatient Therapy services related to Congenital Defects and Birth Abnormalities must be performed by a Physician or by a licensed therapist. Benefits under this section include rehabilitation services provided in a Physician's office, on an outpatient basis, or at a Hospital or Alternate Facility. and are subject to the limitations described in the Outpatient Therapies section.

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

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

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

- COVID-19 diagnostic testing. If you have symptoms, COVID-19 diagnostic testing and associated office visits are covered at no cost to You. Testing for other purposes, such as return to work or checking one's own antibody levels, will not be covered. Please note, mail-order and over-the-counter COVID-19 diagnostic tests do not qualify for reimbursement, unless otherwise required by state or federal law.
- Early medication refills. We are authorizing early medication refills for members who might be impacted by the outbreak. To get your medication refilled early, contact your pharmacist and ask them to request approval. We are following national emergency declaration guidance for the allowance of early medication refills. If the national emergency declaration is lifted, this allowance will be lifted.
- Telehealth Services (online and virtual care) obtained in connection with doctor-ordered COVID-19 testing and diagnosis are covered at no cost to You. Please visit our website at https://brighthealthcare.com/covid- 19 for telehealth services information.

Diabetes Services
Covered Health Services under this section includes diabetic supplies and equipment including: blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by blind individuals;

- insulin pumps and associated appurtenances; One Insulin pump every three (3) years will be covered at 100% of the Allowed Amount and is not subject to the Copayment, or Percentage Copayment. Any supplies used in conjunction with the insulin pump will be subject to the Durable Medical Equipment provision.
- Insulin pumps, both external and implantable, and associated appurtenances, which include:
- batteries;
- skin preparation items;
- adhesive supplies;
- infusion sets;
- insulin cartridges;
- durable and disposable devices to assist in the injection of insulin; and
- other required disposable supplies
- repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
- insulin infusion devices;
- podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes;

- test strips for blood glucose monitors;
- visual reading and urine test strips and tablets which test for glucose, ketones and protein;
- lancets and lancet devices;
- insulin and insulin analogs;
- injection aids, including devices used to assist with insulin injection and needleless systems;
- insulin syringes;
- biohazard disposal containers
- prescription medications which bear the legend "Caution: Federal Law prohibits dispensing without a prescription" and medications available without a prescription for controlling the blood sugar level:
- glucagon emergency kits
- As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies shall be covered if determined to be medically necessary and appropriate by a treating physician or other practitioner through a written order.
- All supplies including medications, and equipment for the control of diabetes shall be dispensed as written, including brand name products, unless substitution is approved by the physician or practitioner who issues the written order for the supplies or equipment.

Brands for these supplies may be determined at Our sole discretion: This plan also covers:

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

Diabetes Services—Emergency Refills

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

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

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

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

Diagnostic Radiology and Imaging

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

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

Depending on the service performed, two bills may be incurred – both subject to any applicable cost-sharing – one for the technical component (the procedure) and another for the professional component (reading or interpretation of the results by a physician or qualified practitioner.

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

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

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

Durable Medical Equipment
Covered Health Services under this section include Durable Medical Equipment (DME) obtained from a Participating DME vendor that meets each of the following criteria:

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

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

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

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

Examples of Durable Medical Equipment include:

- A standard Hospital-type bed, once every five years
- Blood pressure cuffs
- 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 Delivery pumps for tube feedings
- Electric breast pumps
- Equipment to assist mobility, such as a standard wheelchair, once every five years
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage)
- Nebulizers and Peak Flow Meters. Coverage under this plan includes the purchase of one (1) nebulizer in a calendar year period, or one (1) rental per episode, and the purchase of (1) peak flow meter. We will determine if the nebulizer is purchased or rented. Charges are covered at 100% of the Allowed Amount and are not subject to the Annual, Deductible, Copayment, or Percentage Copayment
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors, and masks).

Coverage is available for repairs and replacement, except that:

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

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

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

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

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

Early childhood intervention services must be received from a qualified early intervention services provider and must be Medically Necessary.
The following services are excluded from coverage under this Benefit:

- Assistive technology, unless otherwise covered under this EOC
- Non-emergency medical transportation
- Respite care, and
- Service coordination, other than case management services.

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

Early childhood intervention services are limited to thirty-five (35) visits per calendar year. However, We will not limit coverage to thirty-five (35) visits per calendar year for Medically Necessary Covered Health Services provided in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention.

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

This includes:

- Professional Services including services rendered by the Emergency room Physicians, consulting Physicians, pathologists, radiologists, and anesthesiologists.
- Admission for inpatient hospitalization only during the time that Your condition meets the definition of an Emergency. If You are admitted to a Non-Network facility through the emergency room, You, Your Physician or Hospital must notify Us within 24 hours, or as soon as reasonably possible.

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

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

- After appropriate counseling, Covered Health Services connected with surgical therapies (vasectomy or tubal ligation).
- Implanted/injected contraceptives; and
- Long -acting Long-acting reversible contraceptive devices provided immediately postpartum in the inpatient hospital setting before hospital discharge.
- Information and counseling on contraception;
- Medical supervision in accordance with generally accepted medical practice;
- Physical examinations;
- Related laboratory tests;
- Review of medical history;

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

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

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

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

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

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

Genetic testing is covered only if:

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

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

Hearing 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.

Hearing loss must be verified by a licensed Physician or by an audiologist. The hearing aids shall be medically appropriate to meet the needs of the member according to accepted professional standards. Coverage shall include the purchase of the following, limited to the least expensive professionally adequate device:

- Initial hearing aids and replacement hearing aids not more frequently than once in a 36-month period;

- A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the member;
- Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

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

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

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

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

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

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

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

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

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

Home health services are limited to sixty (60) visits per calendar year.

Hospice Care
Covered Health Services under this section include hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill.
Coverage is available when hospice care is received from a licensed hospice agency. Hospice care includes:
- Routine home care hospice services
- Short-term general inpatient hospice care or continuous home care hospice services, which may be required during a period of crisis, for pain control or symptom management

- Intermittent non-routine respite care on a short-term basis of five (5) days or less

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Coverage under this section includes charges for:

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

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

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

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

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

We may not:

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

- provide financial or other incentives to the attending Physician to encourage the Physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy
Coverage and/or benefits are provided to each Covered Person for reconstructive surgery after mastectomy, including:

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

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

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

We may not:

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

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

Some Covered items may include:

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

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

Mental Health and Substance Use Services
Covered Health Services for the treatment of Mental Health and Substance Use Disorder include inpatient and outpatient Medically Necessary care. Treatment should be provided in the least restrictive clinically appropriate setting. When an inpatient stay is required, it is covered on a semi-private room basis.

<u>Inpatient Care</u>
Inpatient care may include the following services:

- Inpatient hospitalization
- Inpatient detoxification treatment
- Crisis stabilization
- Residential Treatment Facility service
- Inpatient Electroconvulsive Therapy (ECT)

Outpatient Care

- Partial hospitalization program/Day treatment
- Intensive outpatient programs
- Outpatient detoxification programs
- Observation
- Medication management
- Psychological and neuropsychological testing
- Outpatient Electroconvulsive Therapy (ECT)
- Outpatient individual, group, and family therapy
- Evaluation and assessment for mental health and substance use
- Treatment planning
- Transcranial magnetic stimulation

Prior Authorization is not required for emergency services or routine outpatient office visits. All inpatient services and some outpatient services require prior approval by the Plan in order to be covered.

Bright HealthCare complies with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), as well as any additional state parity requirements. Bright HealthCare will not impose more restrictive financial requirements or treatment limitations to mental health or substance use benefits than those on medical/surgical benefits. Covered benefits for the treatment of mental illness and substance use disorder will be covered on the same terms as medical/surgical benefits for any other physical illness.

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

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

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.

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

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

Pediatric Dental Care
For the purposes of this Benefit, coverage is limited to Enrolled Children who are under 19 years of age. Pediatric Dental coverage ends the last day of the month in which the child turns age 19.

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

Refer to your Pediatric Dental Schedule of Benefits for covered services, exclusions and limitations.

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

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

Refer to your Pediatric Vision Services Schedule of Benefits for covered services.

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

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

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

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

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

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

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

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

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

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

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

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

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

- We may transfer You to the nearest appropriate Network or Participating facility for Medical Necessary post-Stabilization care.
- If You receive post-Stabilization care that We have not authorized, care may not be covered.

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

Pregnancy – Maternity Services
Covered Health Services under this section include Benefits for Pregnancy and includes all maternity-related medical services for prenatal care, postnatal care, delivery, Case Management programs for those identified as experiencing a high-risk pregnancy, including Medically Necessary mental, emotional, nervous, or substance use disorder treatment related to pregnancy or postpartum complications, and any related Complications of Pregnancy. This includes charges for a certified nurse midwife.

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

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

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

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

Coverage applies plan benefits to charges for a Provider attending a home birth labor and delivery if the Provider is a Participating Provider.

Coverage is provided for well-baby care in the Hospital or at a stand-alone birthing center, including a newborn pediatric visit and newborn hearing screening. Coverage for congenital defects of a newborn child; or coverage of administration of the newborn screening tests, including for the cost of a newborn screening test kit in the amount provided by the Department of State Health Services.

<u>Statement of Rights under the Newborns' and Mother's Health Protection Act</u>
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 than48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

- Annual Deductible, Copayments, Percentage Copayments, Days' Supply Limits, and other Quantity or

Supply Limits;
- Brand or generic status of medication;
- Eligibility at the time of service;
- The pharmacy filling Your prescription; Tier of the medication on Our Formulary.

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

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

Medication Synchronization Plan
A Medication Synchronization Plan synchronizes the filling or refilling of multiple prescriptions. The prescribing Provider, Pharmacist and Covered Person may jointly approve a medication synchronization Plan for medication to treat a Covered Person's chronic illness. We will cover medications dispensed in accordance with the dates established in the medication synchronization plan. We allow a Pharmacist or Pharmacy to override Our denial of coverage through Our medication synchronization Plan and will provide coverage for the medication if:
- The prescription for the medication is being refilled in accordance with the medication synchronization plan; and
- The reason for the denial is that the prescription is being refilled before the date established by Our general prescription refill guidelines.

We will prorate any Cost-Sharing amount charged for a prescription drug dispensed in a quantity that is less than a 30 days' supply if:
- The Pharmacy or prescribing Provider notifies Us that:
- The quantity dispensed is to synchronize the dates that the Pharmacy dispenses Your prescription drugs; and
- The synchronization of the dates is in the best interest of You; and
- You agree to the synchronization.

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

Pharmacy Network
You must use a Network Pharmacy to receive Benefits under this EOC. If You do not use a Network Pharmacy, You have no coverage under this benefit. To find a Network Pharmacy, visit Our website at www.brighthealthcare.com or call the Member Services 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 maybe oral or injectable. They can be self-administered or administered by a family member.

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

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

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

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

We may periodically change the status of a medication on the Formulary. These changes may occur at your renewal date, and with a 60-day notice to You. Additionally, the status of a medication may change from brand to Generic. Brand name or Generic product status may impact Your costs and coverage under this benefit. When a drug is approved by the FDA, it is not automatically included on our Formulary.

Newly approved drugs will be reviewed against available clinical evidence and considered for addition to the Formulary.

You may view the Formulary at Our website www.brighthealthcare.com or contact Our Pharmacy Member Services at the number listed on Your ID Card to request a copy.

Medical versus Pharmacy Benefits
The drug formulary applies to your pharmacy benefits only. Medications covered under pharmacy benefits typically include self-administered drugs that are picked up at a retail pharmacy or delivered to the home. Drugs administered by a healthcare Provider are typically covered under your medical benefit and subject to the applicable cost-share amount.

Quantity Limit or Supply Limits
Your prescriptions may be limited by quantity, management, or Supply Limits which may reduce the quantity of Your prescription versus the full quantity written by Your prescriber.

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

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

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

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

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

Prior-Authorization

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

In order to find out which medications require Prior Authorization, refer to the Formulary at www.brighthealthcare.com.

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

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

Step Therapy

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

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

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

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

In order to find out which medications require Step Therapy, refer to the Formulary at www.brighthealthcare.com.

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

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

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

Exceptions

Exceptions may be granted in certain circumstances or for emergency or special situations. Your Provider will need to provide certain information in order for us to review an exception request. There is a process to appeal decisions. You received a copy of the appeals process with you EOC. You will receive the information if You are denied a claim.

- If the plan does not cover Your medication or has restrictions or limits on Your medication that will not work for You, You can do one of the following: Ask Your health care provider if there is a covered medication that will work for You.
- Your health care provider can ask the plan to make an "exception" to cover a medication or to remove 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:

Examples of exceptions are:

- A covered has caused a harmful reaction to You
- There is a reason to believe the medication that is 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 covered.

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

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

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

Pharmacy drug samples will not be considered continuation of therapy.

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, visit brighthealthcare.com or call the pharmacy customer service number on Your ID Card.

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

- Initial Review:
  - Standard Requests: 72 Hours
  - Expedited Requests: 24 Hours
- Appeal:
  - Standard Requests: 72 Hours
  - Expediated Requests: 24 Hours

If we grant an approval of an exception request, we will provide coverage until the authorization expires.
If We do not deny a Step-Therapy exception request before the 72 hours after We receive the request, the request is considered granted.

If an exception request also states that the prescribing provider reasonably believes that denial of the request could cause serious harm or death to the patient, the request is considered granted if We do not deny the request within 24 hours after We receive the request.

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

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

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

To qualify for Off-Label use, the drug must also be recognized for the specific treatment for which the drug is being prescribed by one of the following four compendia: (1) National Comprehensive Cancer Network (NCCN); (2) American Hospital Formulary Service (AHFS) DrugDex, (3) LexiCompor (4) Clinical Pharmacology.

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

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

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

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

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

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

Tier 1: Preventive Medications
Tier 2: Preferred Generic Medications
Tier 3: Non-Preferred Generic Medications; Preferred Brand Name Medications
Tier 4: Non-Preferred Generic Medications; Non-Preferred Brand Name Medications
Tier 5: Specialty Medications, Formulary Exceptions
Tier 6: $0 Generic Drugs. This tier is designated for a specific list of generic drugs for certain plans. Not all generic drugs will fall under this tier.

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

Covered Medications and Products

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

- Coverage is limited to prescription products, prescribed by a licensed Provider. Prescription Medications are labeled as "Caution: Federal Law Prohibits Dispensing without a Prescription," "Rx Only," and/or where the State recognizes such products as requiring a prescription or mandates coverage as such
- Insulin is covered as a prescription product, along with syringes, and items required for monitoring diabetes treatment and testing (diabetic test) strips, ketone urine test strips, lancets and related devices, pen delivery system for insulin administration, insulin syringes, visual aids to support the visually impaired with the proper dosing of insulin (except eyewear), Prescription Medications for treatment of diabetes (oral medications), glucagon. Cost- sharing for insulin included in the Formulary shall not exceed $25.00 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription. Our Formulary includes at least one insulin from each therapeutic class
- Phenylketonuria (PKU) formulas and special food products are covered, and subject to the same deductibles, co-pays, and network providers as other prescription products, when used to treat PKU.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins when a prescription is required for dispensing, to prevent or treat a specific medical condition
- Compounded medications are covered when all ingredients in the compounded medication are covered on our formulary and dispensed by a network pharmacy. Compounded medications must contain at least one prescription product for treatment of a covered condition, which has no commercially available prescription alternative. The Plan will only cover the formulary prescription ingredient. Any over the counter medications or ingredients included in the compound are not covered
- Phenylketonuria (PKU) formulas and special food products are covered, and subject to the same deductibles, co-pays, and network providers as other prescription products, when used to treat PKU
- Specialty Pharmaceutical medications, as defined by the plan when dispensed by our Specialty Pharmacy Network Supplier
- Contraceptives medications, devices, and various other products are covered for use as birth control
- Immunizations administered at a Network Pharmacy
- Prescription inhalants to enable persons to breathe when suffering from asthma or other life-threatening ailments. Inhalants may not be limited based upon any restriction on the number of days before an inhaler refill may be obtained if, contrary to those restrictions, the inhalants have been ordered or prescribed by a treating Provider and are Medically Necessary.

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

Prescription Eye Drop Refills

Prescription eye drop refill renewals are allowed for a Covered Person if the refill is requested once70% of the initial days' supply submitted by the pharmacy has been used. For example, after the first twenty-one days for a thirty-day supply of eye drops, forty-two days for a sixty-day supply of eye drops, or sixty-three days for a ninety-day supply of eye drops the last date that the prescription was filled. One additional bottle of prescription eye drops will be allowed if a bottle is requested by the Covered Person or Participating Provider at the time the original prescription is filled; and the original prescription states that one additional bottle is needed by the insured for use in a day care center, school, or adult day program. The additional bottle is limited to one bottle every three months.

Prescription Eye Drop Refills are subject to the plan's annual Deductible, Copayment, or Coinsurance/Percentage amount established for all other prescription drug Benefits under the plan.

Synchronization of Prescription Refills

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

- The medications are covered by the clinical coverage policy.

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

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

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

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

When calculating Your contribution to any Out-Of-Pocket Maximum, Deductible, Copayment, Coinsurance, or other applicable cost sharing requirement, We will include any amount paid by You for a prescription drug that is either:

- Without a Generic equivalent, or
- With a Generic equivalent where You have obtained access to the prescription drug through any of the following:
    - Prior- Authorization
    - Step therapy protocol
    - Our exceptions and appeals process.

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

Federal law prohibits the combination of HSA contributions with third-party payments (such as discounts, vouchers, coupons, rebates, financial assistance, or other out-of-pocket reduction payments). When paying for prescriptions, you can only use third-party payments for preventative care medication or after your minimum contributions have been met. If payments made from an HSA are deemed ineligible, the tax benefits provided by the HSA could be lost for that payment and you may face a serious tax event.

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

- Aspirin
- Bowel preparation for colonoscopy screening; generic and brand prescription and OTC preparations, two (2) per calendar year
- Breast cancer preventive medications, such as tamoxifen, raloxifene, or aromatase inhibitors, for women who are at increased risk for breast cancer and at low risk for adverse medication effects.

- Contraceptives (Barrier/Diaphragms/Cervical caps, Hormonal, Emergency, Implantable, Intrauterine)
- Folic acid – Generic OTC and prescription products 0.4-0.8 mg for women planning or capable of pregnancy
- Iron Supplements – Generic OTC and prescription products for children ages 6 to 12months 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
- Preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition
- Any other preventive medication included in the A or B recommendations of the taskforce or as required by state or federal law. For a complete list of Preventive Care services, visit the USPSTF website: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b- recommendations

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

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

Preventive and Wellness Services
Covered Health Services under this section include A & B Preventive Health Care services recommended by the U.S. Preventive Task Force (USPSTF). Women's Preventive Services Guidelines as recommended by Health Resources and Services Administration, and Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

You can find these services at:
- https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a and-b-recommendations
- https://www.hrsa.gov/womens-guidelines/index.html
- https://www.cdc.gov/vaccines/parents/index.html

When these services are received from a Network Provider, they are covered at no cost to you. The USPSTF may recommend new services throughout the year. New USPSTF recommendations must be in place for at least one year prior to the start of the plan year in order to be covered as preventive services.

Additional Preventive and wellness services covered under this Plan are:
- Bone mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis for:
    - A postmenopausal woman not receiving estrogen replacement therapy; or
    - An individual with:
- Vertebral abnormalities
- primary hyperparathyroidism; or
- a history of bone fractures; or

An individual who is:
- Receiving long-term glucocorticoid therapy, or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
- Screening mammogram, every year, for women age 35 and older. Screening mammogram means a breast cancer screening by low-dose mammography, including 2D and 3D (breast tomosynthesis) for women with or without clinical breast examination

- Diagnostic imaging for women of any age. Diagnostic imaging means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate: (1) a subjective or objective abnormality detected by a physician or patient in a breast; (2) an abnormality seen by a physician on a screening mammogram; (3) an abnormality previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician; or (4) an individual with a personal history of breast cancer or dense breast tissue.
- Cardiovascular disease early detection tests. One of the following non-invasive screening tests for atherosclerosis and abnormal artery structure and function every 5 years when performed by a laboratory that is certified by a recognized national organization. Tests include a computed tomography (CT) scan measuring coronary artery calcifications; or ultrasonography measuring carotid intima-media thickness and plaque. Tests are available to each Covered Person who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age and who is diabetic; or has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.
- Colorectal cancer screening for colorectal cancer starting at age 45 years. At home noninvasive stool DNA colorectal screening tests are subject to Medical Necessity and Preauthorization requirements. Coverage includes all colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of “A” or “B” by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of “A” or “B” in the future; and an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.
- Prostate Screening – A physical examination for the detection of prostate cancer; one prostate specific antigen (PSA) test or an equivalent serological test will be covered per calendar year for men 50 years of age and asymptomatic, or for men 40 years of age with a family history of prostate cancer or another prostate cancer risk factor. More PSA tests will be covered if recommended by a Physician.
- Medically recognized diagnostic examination for the early detection of ovarian and cervical cancer every year for women aged 18 or older. Coverage includes at a minimum, a CA 125 blood test; a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus; and any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer.
- 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
- Hearing screening exams for children through age 17.
- Phenylketonuria screening in newborns
- Any other preventive services included in the A or B recommendations of the task force for the particular preventive health care service or as required by state or federal law. For a complete list of Preventive Care services, please visit the USPSTF website: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b- recommendations

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

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

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

- Prosthetics will be covered in accordance with recommended guidelines and criteria
- Bionic, myoelectric, microprocessor-controlled, and computerized Prosthetics are covered in accordance with Medicare guidelines and criteria
- Artificial face, eyes, ears, and noses

- Speech aid prosthetics and tracheo-esophageal voice prosthetics
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.Benefits include mastectomy bras and lymphedema stockings for the arm
- Wigs for Covered Persons undergoing treatment for cancer or other conditions treated by chemotherapy or radiation. Limited to one (1) wig per calendar year.

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

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

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

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

Implanted Medical Devices

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

Radiation Services - Outpatient

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

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

Benefits under this section include:

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

Rehabilitative and Habilitative Services – Outpatient Therapy

Rehabilitative Services – Outpatient Therapy

Covered Health Services under this section include short-term outpatient Rehabilitative Services, limited to 35 visits combined per calendar year for:

- Occupational therapy
- Physical therapy
- Speech therapy

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

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

Habilitative Services – Outpatient Therapy
Covered Health Services under this section include short-term outpatient Habilitative Services, limited to 35 visits combined per calendar year for:

- Occupational therapy
- Physical therapy
- Speech therapy

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

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

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

Except as required by law, Cosmetic Procedures are excluded from coverage.

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

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

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

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

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

Limited to 25 visits per year calendar year.

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

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

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

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

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

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

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

Tobacco Use Counseling and Interventions
We have resources available to help You stop using tobacco.

The Centers for Disease Control has tips on how You can quit smoking at www.cdc.gov/tobacco/campaign/tips/quit-smoking.

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

- Bupropion
- Chantix .5mg
- Chantix 1mg
- Chantix starter kit
- Nicotine gum
- Nicotine lozenges
- Nicotine patches

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

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

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

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

Coverage is available for:

- A donor who is a Covered Person under this Plan; or
- A recipient who is a Covered Person under this Plan.

Covered Health Services and supplies include:

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

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

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

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

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

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

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 100miles from Your home because treatment is not available In-Network, within Our Service Area.

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

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

If You need assistance with reimbursement for travel expenses, contact Member Services at (844) 926-4524.

In addition to the recipient being covered for the charges associated with the items above, such charges will also be considered covered travel expenses for up to two (2) companions of the recipient. The term companion includes Your spouse, a dependent child, a member of Your family, Your legal guardian, or any person not related to You but actively involved as your caregiver.

Reimbursement for travel expenses for approved Non-Network care may be subject to limitations.

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

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

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

See Your Vision Schedule of Benefits covered.

SECTION 7 – LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

How We Use Headings In This Section

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

Benefit Limitations

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

Benefit Exclusions

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

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

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

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

Acquired Brain Injury

Exclusions from coverage pertaining to treatment for Acquired Brain Injury include but are not limited to:

- Acquired Brain Injury rehabilitation services for any condition other than defined in Federal and/or State Mandated Regulations and *Section 6 – Benefits/Coverage* of this EOC.
- Acquired Brain Injury rehabilitative services for a member who:
  - Is in a vegetative state
  - Has met the goals of the treatment plan (maximum benefit or plateau); or
  - Cannot progress to meet the treatment plan goals
  - The service primary focus is educational in nature, such as vocational rehabilitation or educational training
  - Voluntarily withdraws from the program
- In-home Acquired Brain Injury rehabilitation care that is not Prior Authorized and approved as Medically Necessary prior to service.
- Facility charges for room and board in residential settings are not covered, except when member is receiving Medically Necessary Acquired Brain Injury rehabilitation services in an acute inpatient hospital setting (an acute hospital, rehabilitation hospital, skilled nursing facility) licensed in the state of Texas.
- Acquired Brain Injury Services for conditions such as dementia (including human immunodeficiency virus HIV dementia), cerebral palsy, attention deficit disorder, attention deficit hyperactivity disorder, schizophrenia, pervasive, developmental disorders, including autism, learning disabilities, mental retardation, Down's syndrome, Parkinson's disease and developmental delay.
- Cognitive Behavioral Therapy, except as required by state law for an Acquired Brain Injury and for Covered Services for Mental Health Services
- Coma Stimulation
- Cognitive rehabilitative therapy for member who is receiving custodial care

- Hypnotherapy
- Vocational Rehabilitation

Alternative Treatments
Health care services excluded under this provision include the following:
- Acupuncture
- Acupressure
- Aromatherapy
- 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
- Auditory Integration Therapy (AIT)
- Bio-Energetic Synchronization Technique (BEST)
- Colonic irrigation
- Contact reflex analysis
- Electromagnetic therapy
- Herbal, vitamin, or dietary products or therapies
- Holistic medicine
- Homeopathic medicine
- Hydrotherapy
- Hypnotism
- Iridology - study of the iris
- Magnetic innervation therapy
- Massage therapy
- Naturopathy
- Neurofeedback / Biofeedback
- Orthomolecular therapy
- Reiki therapy
- Rolfing
- Thermography

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

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

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

Cosmetic Procedures
Except as required by law, Cosmetic Procedures that provide no physiologic benefit are excluded from coverage.

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

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

Dental Care
Dental care, except as defined under *Section 6, Pediatric Dental Care* (which includes dental X- rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia) is not covered.

If You have purchased a plan that includes Adult Dental coverage, refer to your *Schedule of Benefits* for information about dental services available to You.

Dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) may be covered when required for the direct treatment of a medical condition for which benefits are available under the EOC, limited to:

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

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

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

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

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

Dental implants, bone grafts, and other implant-related procedures, except when Medically Necessary for the treatment of accident-related dental services received within 12 months from the date of the accident or injury or for the treatment of cleft lip and cleft palate as described under *Cleft Lip and Cleft Palate* in *Section 6 – Benefits/Coverage*.

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

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

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

Devices, Appliances
Health care services excluded under this provision include but are not limited to the following devices or appliances even when prescribed by a Physician.

- Blood Pressure cuff/monitor
- Cold-circulating devices and Cold packs
- Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics

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

Directed Blood Donations
Directed Blood Donations are excluded from coverage.

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

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.: A prescribed drug may be covered if:

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

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

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

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

Some Foot Care Services may be covered for persons with diabetes. Refer to *Diabetes Services* in *Section -6 Benefits/Coverage* section of this EOC.

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

Infertility & Reproductive Services
Health care services excluded are:

- 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
- Artificial insemination, donor semen, donor eggs and Services related to their procurement and storage
- Genetic testing of embryos pre or post implantation Genetic testing of embryos may be authorized in certain circumstances with Prior Approval from the Plan
- Fetal reduction surgery
- Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility
- Medications to treat sexual dysfunction
- Services for treatment of involuntary infertility
- Services to reverse voluntary, surgically induced infertility
- Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue, and ovarian tissue
- Surrogate parenting, donor eggs, donor sperm, and host uterus, except when the surrogate is insured under this plan.

Long Term Care
Care or services received at a Long-Term Care facility or nursing home facility are excluded from coverage under this EOC.

Medical Supplies and Equipment
Health care services excluded under this provision include prescribed or non-prescribed medical supplies and disposable supplies, unless provided through Home Health Care. Examples include:
- Ace bandages
- Adhesive
- Adhesive remover
- Antiseptics
- Appliance cleaners
- Deodorants (except for ostomy)
- Elastic stockings
- Filters
- Gauze and dressings
- Lubricants
- Tape
- Tubings and masks

Refer to Durable Medical Equipment (DME) and Medical Supplies and Disposable Items listed under *Section 6-Covered Health Services* for items which are covered by the Plan.

Mental Health or Substance Use Services
This plan excludes the following services related to Mental Health or Substance Use treatment:
- Court-ordered testing and testing for ability, aptitude, intelligence, or interest.
- Evaluations for purposes other than mental health treatment.
- Inpatient detoxification outside of a hospital setting is covered when subacute biomedical, emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute care general hospital or a medically managed inpatient treatment program.
- Inpatient stays intended as a change of environment or that primarily treat long-term social needs.
- Mental Health Services ordered by a course, to be used in a court proceeding, or as a condition of parole or probation, unless a plan Physician determines such services to be Medically Necessary.
- Residential treatment services for individuals with cognitive limitations that make it unlikely to benefit from residential treatment.

- Services which are custodial or residential in nature.
- Services received at a Residential Treatment Center
- School-based special education, counseling, therapy, or care for learning deficiencies or behavioral problems, whether associated with manifest mental disorder.
- Wilderness Treatment Programs

Neurobiological Disorders
Health care services excluded under this provision include services such as Mental retardation as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association; Tuition or services that is school-based for children and adolescents under the Individuals with Disabilities Education Act; Learning, motor skills, and primary communication disorders as defined in the current edition of Diagnostic and Statistical Manual of the American Psychiatric Association and which are not part of Autism Spectrum Disorder; Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by Us.

Nutrition
Health care services excluded under this provision include the following:
- Individual and group nutritional counseling, except for medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
  - Nutritional education is required for a disease in which patient self-management is an important component of treatment
  - There exists a knowledge deficit regarding the disease that requires the intervention of a trained health professional
- Enteral feedings, even if the sole source of nutrition except for the first 31 days of life, and for the treatment of Phenylketonuria (PKU)
- Infant formula and donor breast milk except for babies in neo-natal intensive care or under special care.
- Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods)

Pediatric Dental Care Exclusions and Limitations
Refer to your Pediatric Dental Care Schedule of Benefits.

Personal Care, Comfort, or Convenience
Items excluded under this provision include the following:
- Beauty/barber services
- Guest service
- Telephone
- Television
- Supplies, equipment, and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners, air purifiers and filters, dehumidifiers
  - Batteries and battery chargers
  - Car seats
  - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners
  - Electric scooters
  - Exercise equipment
  - Home modifications such as elevators, handrails, and ramps
  - Hot tubs
  - Humidifiers
  - Jacuzzis/whirlpools/saunas

- Mattresses
- Medical alert systems
- Motorized beds
- Music devices
- Non-medically necessary enhancements of equipment and devices
- Personal computers
- Pillows
- Power-operated vehicles
- Radios
- Speech generating devices
- Stair lifts and stair glides
- Strollers
- Treadmills
- Vehicle modifications such as van lifts
- Video players

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

- Cosmetic Procedures. See the definition in the Definitions section. Examples include:
  - Fat injections or fat grafting.
  - Hair removal or replacement by any means
  - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
  - Pharmacological regimens, nutritional procedures, or treatments.
  - Scar or tattoo removal or revision procedures (such as salabrasion, laser removal, chemosurgery, and other such skin abrasion procedures).
  - Skin abrasion procedures performed as a treatment for acne.
  - Treatment for skin wrinkles or any treatment to improve the appearance of the skin, including blepharoplasty or eyelid surgery.
  - Treatment for spider veins or varicose veins. This includes, but is not limited to vein stripping, laser procedures or surgery.
- Breast reduction surgery that is determined to be a Cosmetic Procedure. Except to treat a physiologic functional impairment required by the *Women's Health and Cancer Right's Act of 1998* and described under Reconstructive Services in
- *Section 6- Benefits/Coverages*.
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.
- Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.
- Treatment of benign gynecomastia (abnormal breast enlargement in males).
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
- Wigs, toupees, hair transplants or hair weaving, except as covered under Prosthetic Devices for Covered Persons undergoing treatment for cancer or other conditions treated by chemotherapy or radiation therapy.

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

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

- Allergy serum.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury

- Biological sera, blood, blood products or plasma.
- Drug classes in which at least one drug in the class is available over-the-counter;
- Early prescription refills to replace a lost, stolen, or destroyed prescription or prescription supplies, or exceeding the Day's Supply Limit, Quantity or Supply Limits.
- General vitamins except as described under the *Preventive and Wellness Services* of the *Benefits/Coverage (What is Covered)* section of this EOC.
- Human Growth Hormone prescribed to adults for any reason.
- Immunizations - benefits are not available for immunizations including, but not limited to, autogenous vaccines and immunizations related to foreign travel. Coverage is provided for childhood immunizations, pneumococcal and flu vaccinations, and immunizations required because of an injury or immediate risk of infection.
- Marijuana, including but not limited to medical marijuana for any reason.
- Medication prescribed for the treatment of hair loss
- Medications available as bulk powder only.
- Medications for the treatment of Infertility.
- Medications for conditions that are excluded from coverage.
- Medications not approved by the FDA.
- Medications to treat hyperhidrosis.
- Medications which are labeled or deemed Investigational or Experimental, including regimens that are unproven.
- Medications determined to be ineffective, unproven, or unsafe. Drugs with no approved FDA indications and DESI (Drug Efficacy Study Implementation) products, i.e. those rated by the FDA has not proven safe and effective.
- Medications prescribed solely for cosmetic purposes
- Medications used for prevention of diseases not endemic to United States.
- Medications used to treat Sexual Dysfunction.
- Non-Prescription Medications (medications that do not require a prescription), unless specifically included as covered elsewhere in this document, or mandated by Law.
- Off-label use of medications unless required by Law, then allowed in accordance with Law.
- Oxygen, Medical Devices or Equipment, unless specifically listed as covered.
- Prescribed and non-prescribed outpatient supplies, other than diabetic supplies and inhaler spacers specifically stated as covered.
- Prescription Drug Products dispensed outside the United States,
- Prescription Drug Products for any condition, Injury, Sickness, or Mental Illness arising out of, or in the course of, employment for which Benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such Benefits is made or payment or Benefits are received. Prescription Drug Products obtained through a Non-Network Pharmacy.
- 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, including New Prescription Drug Products or new dosage forms that We determine do not meet the definition of a Covered Health Service.
- Prescription drugs with a non-prescription equivalent except as described under the *Preventive and Wellness Services* of the *Benefits/Coverage (What is Covered)* section of this EOC.
- Topical medications for the treatment of onychomycosis of the toenails.
- Unit-dose or re-packaged medications, or costs related to re-packaging of available covered medications.
-

Prescription Drugs Limitations

Health care services limited under this provision include the following:

- 90-day supply of covered medications per prescription is allowed, other quantity limits maybe applied to claims.
- Certain medications are subject to Our utilization review process and quantity limits. In addition, certain medications may be subject to any quantity limits applied as part of our split fill program. For most

medications, 90-day supplies will be covered when filled at a network pharmacy. No more than a 30- day supply of Specialty Medications will be covered and dispensed at a time.

- If a member or prescriber requests a brand medication when there is a generic equivalent, the brand medication will be covered up to the charge that would apply to the generic medication, minus any required copayment.
- If You or Your Provider requests that a brand medication be dispensed as written when there is a generic equivalent and it is approved through the exception process as Medically Necessary, You will be responsible for the tier 3 cost share plus the difference in drug cost between the brand and generic.
- The copayment for a medication will not exceed the cost of the medication.

Private Duty Nursing
Private Duty nursing care that is provided by a licensed nurse in the patient's home is not covered. Home Health Care services are available, refer to *Section 6 – Benefits/Coverage* for available Home Health Care services.

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

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

Providers
The following provider services are excluded from coverage under the plan:

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

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

Services Received Outside of Your EOC Coverage Period
Health services received prior to your EOC Effective Date, or after the date Your coverage ends are excluded under this provision. This applies to all health services, even if Prior Authorization is in place and/or the services are required to treat a medical condition that arose before the date Your coverage under this *EOC* ended.

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

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

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

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

Temporomandibular Joint Disorder (TMJ)
Services for the treatment of TMJ, including diagnostic X-rays, lab testing, physical therapy, and surgery are excluded from coverage under this plan.

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

Travel
Health care services excluded under this provision include the following:
- Non-Network Health services provided in a country, outside the United States
- Travel or transportation expenses, even though prescribed by a Physician, except as described in the Transplant provision of the *Benefits/Coverage (What is Covered)* section of this EOC.

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

Vision Services
Health care services excluded under this provision include the following:
- Purchase cost and fitting charge for eyeglasses, frames, or contact lenses, except as covered under Pediatric Vision Services.
- Adult eye exams except when Medically Necessary and performed by an Ophthalmologist for medical conditions of the eye, not including keratoconus. If You have purchased a plan that includes Adult Vision coverage, refer to your *Schedule of Benefits* for information about vision services available to You.
- Eye exercise therapy
- Implantable devices used to correct a refractive error (such as Intacs corneal implants).
- Purchase cost and fitting charge for eyeglasses, frames, or contact lenses, except as covered under Pediatric Vision Services.

- Surgery that is intended to allow You to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

These exclusions are not applicable to coverage for services included in the *Vision Services* section.

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

- Administrative services.
- Aids or devices that assist with non-verbal communications.
- Ambulance services that are not Medically Necessary.
- Autopsy, except as may be reasonably required by Us at Our own expense.
- Charges for services provided by a stand-by Physician.
- Charges in excess of the Allowed Amount or in excess of any specified limitation.
- Charges unsupported by medical records.
- Claims received by us after 12 months from the date service was rendered, except in the event of legal incapacity or as required by law.
- Court-ordered testing, except for mental health or substance abuse testing or treatment as required by state law.
- Gym fees or memberships.
- Health services received in consequence of being intoxicated or under the influence of any narcotic, unless administered on the advice of a physician.
- 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 for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements.
- Health services and supplies that do not meet the definition of a Covered Health Service -see the Definitions section.
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this EOC.
- Health services while on active military duty; and
- Hypoglossal nerve stimulation for sleep studies is not covered.
- Inpatient stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- Long-term care/Nursing home care.
- Long-term (more than 30 days) storage of products such as cryopreservation of tissue, blood, and blood products.
- Medical services and procedures that are not legal.
- Missed and canceled appointments.
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under this EOC when:
    - Conducted for purposes of medical research.
    - Related to judicial or administrative proceedings or orders unless Medically Necessary and for covered services under this EOC.
    - Required to obtain or maintain a license of any type.
    - Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage, or adoption.
- Preventive Care services rendered by an out of network provider or at an out of network facility.
- Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Services performed as a result of complications related to or attributable to services that are specifically excluded from coverage under this EOC.

- Services received because of participation in an insurrection, rebellion, or riot.
- Services received as a result of a commission of, or an attempt to commit a felony (whether or not charged) or as a result of being engaged in an illegal act or occupation.
- Virtual colonoscopy including CT colonography and capsule endoscopy and colonography
- Virtual coronary angiography and coronary calcium scans.
- Voluntary or elective medical or surgical abortions and any related services, drugs or supplies are excluded. This exclusion shall not apply to any abortion performed due to a medical emergency. For purposes of this exception, “medical emergency” means a life- threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places a woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.

SECTION 8 – MEMBER PAYMENT RESPONSIBILITY

Your Responsibilities

Show Your ID Card

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

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

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

Pay Your Share

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

Pay the Cost of Excluded Services

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

Our Responsibilities

Pay for Our Portion of the Cost of Covered Health Services

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

Pay Network Providers

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

Offer Health Education Services to You

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

SECTION 9 – CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

If You Receive Covered Health Services From A Network Provider

We pay Providers for Your Covered Health Services. You are responsible for meeting Your Annual Deductible and for paying any required Copayments and Coinsurance. Copayments are normally required at the time of service. Deductible and Coinsurance amounts may be due later when You receive a bill from Your provider. If you receive a bill from Your provider, We encourage you check Your Explanation of Benefits, call Member Services or login to Your Member Portal to make sure that the charges You are being billed for are consistent with what We have paid.

Assignment Of Benefits

If a provider or other party receives written permission from a Covered Person to receive payment for services directly from the Us, We will honor the agreement and pay the Provider. When You see a Non- Network Provider, they may require payment from You, and You may have to submit the claim to Us. We may choose to pay You or to pay the Non-Network Provider directly, if covered.

Required Claim Information

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

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

Notice Of Claim

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

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

Proof Of Loss

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

Claim Forms

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

You may find the required claim forms on our website at www.brighthealthcare.com or by calling Member Services at the number listed on Your ID Card.

Payment Of Claims Upon Death

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

Finalization Of Claims

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

Timely Filing

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

Bright HealthCare Insurance Company of Texas
P.O. Box 1357
Portland, ME 04104

Time Of Payment Of Claims

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

SECTION 10 – GENERAL EOC PROVISIONS

Administrative Services

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

Change Of Beneficiary

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

Conformity With State Statutes

Any provision of this EOC that, on its Effective Date, is in conflict with the state statutes 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.

Coordination Of Benefits (COB)

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. 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 accord with its EOC 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 equal 100 percent of the total allowable expense.

Definition

(1) 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. Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health

insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage under (a)(1) or (a)(2) 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.

(b) "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies 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 like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person 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 equal 100 percent of the total allowable expense.

(c) "Allowable expense" is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any plan covering the person. 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 person is not an allowable expense. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person 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 person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, 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 person is covered by two 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 person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician 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 health care provider's or physician's contract permits, the negotiated fee or payment must 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 covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.

(d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care provider or physician. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(e) "Closed panel plan" is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.

(f) "Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

Order Of Benefit Determination Rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

(a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

(b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this EOC is always primary unless the provisions of both plans state that the complying plan is primary.

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

(d) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

(e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a noncontracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(f) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination
among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

(g) If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

(h) Each plan determines its order of benefits using the first of the following rules that apply.

(1) Nondependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, Plan holder, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, Plan holder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(B) For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

(i) if a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

(ii) if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.

(iv) if there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) the plan covering the custodial parent;

(II) the plan covering the spouse of the custodial parent;

(III) the plan covering the noncustodial parent; then

(IV) the plan covering the spouse of the noncustodial parent.

(C) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

(D) For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, (h)(5) applies.

(E) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent child's parent(s) and the dependent's spouse.

(3) Active, Retired, or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that has covered the person as an employee, member, plan holder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect On The Benefits Of This Plan

(a) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(b) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance With Federal And State Laws Concerning Confidential 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. Organization responsible for COB administration] will comply with federal and state law concerning confidential information 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 Organization responsible for COB administration any facts it needs to apply those rules and determine benefits.

Facility Of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Organization responsible for COB administration 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. Organization responsible for COB administration 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.

Right Of Recovery

If the amount of the payments made by Organization responsible for COB administration is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Eligibility For Medicaid

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

Eligibility For Medicare

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

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.

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.

Extension Of Benefits

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

Fraudulent Insurance Acts Notice

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

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

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

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

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

If You Are Hospitalized When Your Coverage Begins

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

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

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.

Incontestability

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

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

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

Information And Records

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

We may use Your individually identifiable health information to administer this EOC and pay claims, to identify procedures, products, or services that You may find valuable, and as otherwise permitted or required by law. We may request additional information from You to decide Your claim for Benefits. We will keep this information confidential. We may also use Your de-identified data for commercial purposes, including research, as permitted by law. More detail about how We may use or disclose Your information is found in Our Notice of Privacy Practices. You can obtain Our Notice of Privacy Practices in the Member Hub, on our website at , in Your welcome kit that included Your Identification Card, or by contacting Bright HealthCare Plan Member Services at (844) 926-4524 have the right to release any and all records concerning health care services, which are necessary to implement or administer the terms of this EOC, for appropriate medical review or quality assessment, or as We are required to do by law or regulation. During and after the term of this EOC, We and Our related entities may use and transfer the information gathered under this EOC in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to Our Notice of Privacy Practices.

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

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

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

Inspection Of EOC

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

Integration Of Medicare Benefits

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

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

Interpretation Of Benefits

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

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

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

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

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

Limitation Of Action

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

Non-Discrimination

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

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

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

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

To the extent that state law applies, this EOC is governed by the laws of the state in which this EOC is issued.

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.

Patient Advocacy
We shall not prohibit a Provider from discussing any specific or all treatment options with You irrespective of the Our position on those treatment options or from advocating on behalf of You within the utilization review, grievance, or appeals processes established by the Us in accordance with any rights or remedies available under applicable State or federal law.

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

Premium Payments from Third-Party Payors
We require each plan holder to pay his or her applicable Premiums. The following are the ONLY acceptable third parties who may pay Premiums on your behalf:

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

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

Quality Management Program
We have developed a Quality Management Program to help Us provide You with quality health care and services.

Through the Quality Management Program, We monitor care and services provided to Our members and use the results to identify areas of improvement and implement corrective action, as necessary.

Our Quality Management Program focuses on a number of activities including, but not limited to:

- Patient Safety;

- Confidentiality;
- Preventive health;
- Disease and case management;
- Coordination and continuity of care;
- Quality of care; and
- Appeals and grievances.

Rebates And Other Payments

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

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

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

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. Bright HealthCare's recovery limit is limited to payments made or costs of benefits provided for that injury.

- Third parties, including any person alleged to have caused You to suffer injuries or expenses.
- Any person or entity who is or may be obligated to provide Benefits or payments to You, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers, or third party administrators. *We may not pursue a recovery against a covered individual's first-party recovery. We may pursue recovery against uninsured/underinsured motorist coverage or medical payments coverage only if the covered individual or the covered individual's immediate family did not pay the premiums for the coverage.*
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.
- These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- You will cooperate with Us in protecting Our right to reimbursement, including, but not limited to:
  - Providing any relevant information requested by Us.
  - Signing and/or delivering such documents as We or Our agents reasonably request to secure the reimbursement claim.
  - Responding to requests for information about any accident or injuries, and making court appearances, and
  - Obtaining Our consent or Our agent's consent before releasing any party from liability or payment of medical expenses.
- Failure to cooperate in this manner shall be deemed a breach of contract and may result in the instigation of legal action against You.

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

Time Limit On Certain Defenses

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

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

Unpaid Premiums

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

Use And Disclosure Of Certain Types Of Medical Information

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

Workers' Compensation

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

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

You must pursue Your rights under the Workers' Compensation Act or any other laws that may apply to Your situation. This includes filing an appeal with the Texas Department of Labor, if necessary.

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

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

- If You have an appeal for Worker's Compensation pending, 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 state 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.

Your Relationship With Providers

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

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

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 healthcare that You may receive. The plan pays for Covered Health Services, which are more fully described in this EOC.
- The plan may not pay for all treatments You or Your Physician may believe are necessary. If the plan does not pay, You will be responsible for the cost.

SECTION 11 – TERMINATION/NONRENEWAL/CONTINUATION

General Information About When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained below, as permitted by law.

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

- We receive a written notice from You instructing Us to cancel Your or Your Dependent's coverage. If any Premium has been paid for the time period following the requested date of termination and no claims have been submitted to Us for dates of service after the requested date of termination, We will refund or credit that Premium within 30 days of the request for termination. In the case of retroactive terminations, We will not refund or credit any Premium when claims have been submitted to Us for dates of service after the requested date of termination.
- You no longer qualify as an Eligible Individual.
- Loss of eligibility due to the Subscriber no longer living or working in the Service Area served by Us.
- Coverage will end if Premiums are not paid when they are due. A Grace Period of three months for individuals receiving federal insurance subsidies will be allowed for the payment of all outstanding Premiums. If the full balance of outstanding Premium is not paid within Your grace period, coverage will end on the last day of the first calendar month of the grace period. For non-subsidized Members, a 30-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 of the month in which Your Premiums were paid and Your EOC did not have a delinquency. We will provide You notice of Your nonpayment before cancelling Your EOC. We will not pay for any services received on or after the date Your coverage ends.
- A Dependent Child enrolled with an adult Subscriber reaches age 26. If the Dependent Child is incapable of self-sustaining employment by reason of intellectual or physical disability and is chiefly dependent upon the plan holder for support and maintenance, the Dependent can remain as a Dependent Child under the EOC. Proof of such dependency may be required within 31 days of the Child's attainment of the limiting age, but not more frequently than annually.
- The Spousal relationship, as referred to in Our definition of Spouse, is legally dissolved. Coverage for the Dependent Spouse will end on the last day of the month in which the Spousal relationship is legally dissolved. Once We receive notice of the dissolution, We will adjust Your coverage and Premium.
- The Subscriber's death. Upon the death of the Subscriber, Dependent coverage may be continued under a new Plan with a new ID number. Contact Customer Service at the number on Your ID Card for additional information.
- We decide to discontinue a particular Plan. In this case We will provide ninety (90) days advance written notice to the Subscriber prior to termination of coverage.
- We stop operations. We must pay for services for the rest of the time that premiums have already been paid.
- Fraud, including improper use of Your ID card or intentional misrepresentation of material fact. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact may result in termination or rescission of this EOC. This EOC may also be terminated if You participate in or permit fraud or deception by any Provider, vendor, or any other person associated with this EOC. 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 EOC. We will provide You with thirty (30) days written notice prior to rescinding coverage.

You request termination of the EOC in writing.

We will provide You with a thirty (30) day advanced written notice prior to the termination of Your coverage, except if such termination is the result of fraud or intentional misrepresentation of material fact.

Grace Period

A Grace Period of 3 months for individuals receiving federal insurance subsidies will be allowed for the payment of all outstanding premiums. If the full balance of outstanding premium is not paid within Your grace period, coverage will end on the last day of the first calendar month of the grace period. For non-subsidized Covered Persons, a 31-day grace period will be allowed for the payment of all outstanding premiums. If the full balance of outstanding premium is not paid within Your grace period, coverage will end on the last day for which You have paid Your premium. We will provide You notice of Your nonpayment before cancelling Your EOC. We will not pay for any services received on or after the date Your coverage ends.

Reinstatement Of Coverage

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

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

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

SECTION 12 – APPEALS AND COMPLAINTS

Cultural And Linguistic Handling Of Denials And Appeals

We are required to provide Culturally and Linguistically Appropriate Notices, which means that We will provide the following:

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

What To Do If You Have A Question

Contact *Member Services* at 1-(844) 926-4524. *Member Services* representatives are available to take Your call and resolve Your inquiry.

What To Do If You Have A Complaint

Contact *Member Services* at1-(844)926-4524. *Member Services* representatives are available to take Your call.

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

Bright Health Group
PO Box 1519
Portland, ME 04104

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

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

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

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

What Is An Adverse Determination?

Adverse determination means a determination by us that health care services provided or proposed to be provided to a covered person are not medically necessary or are experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. In the case of a prescription drug, it is an adverse determination if we refuse to provide benefits if the drug is not included in the formulary and your physician has determined that the drug is medically necessary.

Appeal Of An Adverse Determination

If You disagree with an Adverse Determination and wish to appeal, You may request a review of the Adverse Determination. We have an internal review process. Adverse determinations involving life threatening conditions, prescription drugs, or intravenous infusions are entitled to immediate appeal to an independent external review

entity through the independent external review process. See the “Independent External Review” and “Expedited Independent External Review” sections, below.

Appeal of a Complaint

The Appeals process if available if You disagree or are not satisfied with the resolution of your complaint. For appeals involving going emergency or continued hospitalization, Bright Health will make a determination within 1 business day. Standard complaint appeals will be processed within 30 days.

Internal Review Process

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

Bright Health Group
PO Box 1519
Portland, ME 04104

Your request for an appeal must include:

- Description of the Adverse Determination
- Reason You disagree with the Adverse Determination; and
- Any documentation (including medical records) or other written information to support Your position
- If Your appeal is related to a claim, the request for the appeal must include the following information:
    - Patient's name and the identification number from the ID card
    - Date(s) of the medical service(s)
    - Provider's name

Appeal Review Process

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

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

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

Notice of Appeal Determination

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

Prescription Drugs

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

Standard Appeal

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

Retrospective Appeal

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

Expedited Appeals

Expedited Appeal Review Process

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

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

An expedited appeal request does not need to be submitted in writing. An expedited appeal may be requested by calling us directly at the Member Services number listed in *Section 2 of this EOC and on Your ID Card.*

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

Notice of Expedited Appeal Determination

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

Expedited appeal requests will be decided based on the medical immediacy of Your condition, procedure, or treatment, but in no event later than 1 business day or 72 hours (whichever is sooner) from the date of Our receipt of the information necessary to complete the appeal.

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

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

Bright HealthCare reserves the right to reclassify an expedited/urgent appeal or grievance based on member diagnosis and clinical review of medical documentation as outlined in MED-094 UM Reclassification of Review Requests.

Independent External Review

Independent External Review Process

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

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

You may request an external review without completing the internal appeals process, in the following cases:

- Urgent Care situations (expedited external review may be initiated at the same time as expedited internal appeals)
- Failure to comply with all requirements of the internal appeals process except in cases where the violation was:
    - De minimis
    - Non-prejudicial
    - Attributable to good cause or matters beyond the plan's or issuer's control
    - In the context of an ongoing good-faith exchange of information
    - Not reflective of a pattern or practice of non-compliance

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

We participate in the federal external review process, which is administered by the Department of Health and Human Services and currently managed by MAXIMUS (the "IRO"). We will forward a copy of Your request to the IRO. You may submit additional information for consideration directly to the IRO, and the IRO will forward Us a copy of any information You send them. We will send the IRO the documents and information We considered in making Our Adverse Determination. the IRO will provide You with an index of all materials that We submit. Upon request, We will provide You with all relevant information we supply to the IRO that is not confidential or privileged under state or federal law concerning the case under review. The IRO will notify You and Us if additional information is required.

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

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

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

Expedited Independent External Review

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

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

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

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

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

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

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

Bright HealthCare reserves the right to reclassify an expedited/urgent appeal or grievance based on member diagnosis and clinical review of medical documentation as outlined in MED-094 UM Reclassification of Review Requests.

Important Notice – Claims Disputes
Should a dispute concerning a claim arise, call Us at 1-(844)-926-4524. If the dispute is not resolved, You may contact the:

Texas Department of Insurance at:
1-800-578-4677
www.tdi.texas.gov or:

333 Guadalupe
Austin, TX 78701

PO Box 149104
Austin, TX 78714-9104

SECTION 13 – EOC AND RATE CHANGES

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.

Changes In Covered Persons

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

Changes To Premium Charge

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

Changes To This EOC

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

Guaranteed Renewable

This EOC is Guaranteed renewable which means that this EOC will renew each year on January 1 unless terminated earlier in accordance with EOC terms listed in *Section 11 – Termination/Nonrenewal/Continuation.*

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.

Other Insurance With This Insurer

If while covered under this EOC, You are also covered by another individual Plan issued by Us, You be entitled to the benefits of only one EOC. You may choose this EOC or the Plan under which You will be covered. We will then refund any premium received under the other EOC covering the time period both EOC were in effect. However, any claims payments made by Us under the EOC You elect to cancel will be deducted from any such refund of premium.

Renewal Of EOC

If You do not take action to cancel or change Your plan or if we have not been otherwise notified, Your EOC will renew automatically each year on January 1st at the new premium amount. Prior to the renewal, you will be notified of the new premium amount prior to the renewal. In the event of a rate increase, We will provide written notice of the premium change at least 60 days before the change takes effect.

SECTION 14 – DEFINITIONS

Accident or **Accidental Injury –** Means an unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic injury. This does not include injuries caused by surgery or treatment for a disease or illness.

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

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

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

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

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

Alternate Facility – a health care facility that provides outpatient health care services. An Alternate Facility may also provide Mental Health or Substance Abuse Services on an outpatient or inpatient basis. Or a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

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

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

Ancillary Services –- services that support the work of the physician that is treating You. Such 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/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 Allowed Amount. The Annual Deductible does not include any amount that exceeds the Allowed Amount.

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

Applied Behavioral Analysis (ABA) – the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial

assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

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

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

Brand Name/Brand Drugs – 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, First Data Bank, 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.

Calendar Year- January 1 through December 31.

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

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

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

- natural child
- stepchild
- legally adopted child
- foster child
- child placed for adoption, including a child who is a subject of a suit of adoption.
- child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order
- child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's Spouse
- grandchild who is dependent of the Covered Person for tax purposes at the time of application for coverage

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Custodial Care – services that are any of the following:

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

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

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

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

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

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

Designated/Network 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.

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

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

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

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

Effective Date- the date Your EOC**.** 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.

Eligible Individual – a person eligible to enroll in an EOC**.**

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

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

Emergency Ambulance Services – services provided by an ambulance service following the onset of a medical condition that manifests itself by symptoms of pain, illness, or injury that the absence of accessing an ambulance or emergency response by 911 or a designated telephone number to reach a public safety answering point and receiving time sensitive medical attention could reasonably be expected to result in any of the following:

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

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

Enrolled Dependent – an eligible Child or Spouse who is enrolled under this EOC.

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

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

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

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

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

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

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

Formulary/Formulary Drugs – list of medications covered by Us. Products that are on the Formulary generally cost less than products that are not on the Formulary.

Generic – a Prescription Drug Product that is 1) 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, First Data Bank, that classify drugs as either brand-name or Generic based on a number of factors. Generic drugs usually cost less than Brand-Name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as Brand-Name drugs.

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 Factor Means:

- Health status;
- Medical condition, including both physical and mental illness;
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability, including conditions arising out of acts of family violence; and
- Disability

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

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

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

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

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

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

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

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

Inpatient Stay – – full-time inpatient confinement following admission to a Hospital or other Facility providing Medically Necessary 24-hour treatment under the direction of a Physician

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

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

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

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

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

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

- Obtained through a pharmacy.
- Specifically designated and manufactured for the treatment of Inherited Enzymatic Disorders caused by gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist.
- Essential to a person's optimal growth, health and metabolic homeostasis; and
- 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 least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A "setting" may be Your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only Your medical condition is considered in deciding which setting is Medically Necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non- medical factor is not considered. As Your medical condition changes,

the setting You need may also change. Ask Your physician if any of Your services can be performed on an outpatient basis or in a less costly setting.

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

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

Mental Health Disorder or Mental Illness – Conditions as defined in the *Diagnostic and Statistical Manual* of Mental Disorders or the most recent edition of the International Classification of Diseases.

Mental Health Benefits – Covered Health Services for the treatment of mental health conditions, as defined in the Diagnostic and Statistical Manual of Mental Disorders or the most recent edition of the International Classification of Diseases.

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

Network – Physicians, Facilities, or pharmacies are contracted with Us to provided Covered Health Services to You.

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

Network Pharmacy – a pharmacy that has:

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

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

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

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

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

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

Non-Network Pharmacy – pharmacy that does not participate in the contract with Our Pharmacy Services Vendor. These pharmacies may fill Your prescriptions, but Your plan does not provide any coverage for prescriptions filled at these pharmacies.

There is NO COVERAGE for medications received from a Non-Network Pharmacy.

Non-Preferred Prescription Drug - A drug designated by Us as Non-Preferred on Our Formulary. Non-Preferred Prescription Drugs may be Brand name drugs or Generic drugs.

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

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

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

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

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

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

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

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

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

The term Physician does not include a Member, a Member’s Spouse, Child, brother, sister, parent, or grandparent.

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

Plan Year – is a traditional calendar year.

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

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

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

Pregnancy –medical services which include the following:

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

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

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

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

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

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

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

Primary Care Physician (PCP) – a Physician, including a women's principal health care Provider, who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice, or general medicine. A Primary Care Physician directly provides or coordinates a range of health care services for a patient.

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

Prior-Authorization Medications – some medications may require Prior 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.

Private Duty Nursing – care in which a private duty nurse provides long-term, comprehensive hourly nursing care in a patient's home.

Prosthetic Device – an artificial device designed to replace, wholly or partly, a limb or other missing body part.

Provider – a person (such as a Physician or practitioner) or a facility (such as a Hospital) that provides services or supplies related to medical care, or a Pharmacy legally licensed to dispense drugs.

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

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

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

Referral – the approval you must receive from PCP in order for the services of a Participating Provider, other than the PCP, participating Obstetrician/Gynecologist or participating vision care Provider or pediatric dental care Provider to be covered.

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.

Residential Treatment Facility – health care facilities licensed by their state, district, or territory to provide residential treatment services for Mental Illness and/or Substance Use Disorder. Residential Treatment Facilities are accredited by a nationally recognized organization and provide a planned and structured regimen of 24-hour evaluation, treatment, and comprehensive specialized services for a individuals medical, mental health, or substance use disorder needs. These Facilities do not include group homes, halfway houses, or other types of facilities which primarily provide supportive living environments and address long-term social needs rather than delivering medically necessary, clinically-directed care. In addition to these requirements, residential treatment facilities that provide inpatient detoxification programs in a residential setting also provide 24/7 patient medical monitoring and on-site nursing care.

Residential Treatment Services – Covered Health Services in an appropriately licensed Facility which provides 24-hour professionally-directed active treatment for Mental Illness and/or Substance Use Disorder for individuals who do not require acute inpatient care but require a 24-hour treatment program due to the severity of their needs being unable to safely be treated in an outpatient setting. Residential treatment services are staffed 24/7 with licensed medical, nursing, and/or behavioral health professionals who provide daily treatment interventions under physician-directed programming. Residential treatment services must be pre-approved by the plan. All services must be performed within the scope of the license or certification to be eligible for reimbursement.

Responsible Adult – in the case of EOC/ that covers only children, the person who enters into this EOC on behalf of the child(ren).

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

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

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

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

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

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

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

Sickness/Illness – Physical disease, physical illness and Pregnancy.

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

Specialist –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 Non-Network claims.

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

Spouse – Your legal Spouse defined by state law.

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

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

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

Substance Use Disorder – as defined in the Diagnostic and Statistical Manual of Mental Disorders or the most recent edition of the International Classification of Diseases.

Substance Use Disorder Benefits – Covered Health Services for the treatment of substance use disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders or the most recent edition of the International Classification of Diseases.

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

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

Telemedicine/Telemedicine/Virtual Care delivery of medical services and diagnosis, consultation, or treatment using interactive audio, interactive video, or interactive data communication

Therapeutically Equivalent – when Prescription Drug Products can be expected to produce essentially the same therapeutic outcome in treating an Illness or symptom.

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

Urgent Care - unscheduled services for a member's condition that requires medical attention not amenable to scheduling, to avoid a serious risk of harm.

Urgent Care Center A walk-in care facility that treats injuries or illnesses that require care right away, but that are not serious enough to require an emergency room visit. 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 reasonable median rate paid for similar healthcare services within the surrounding geographic area in which the services were rendered. The surrounding geographic area may be determined by the type of service and the access to that service in the geographic region.

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

SECTION 15 – NOTICES OF CERTAIN MANDATORY BENEFITS

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

Mastectomy Or Lymph Node Dissection

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

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

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

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

If any person covered by this plan has questions concerning the above, please call Bright Health at (844) 926-4524, or write us at P.O. Box 1357, Portland, ME 04104.

Coverage And/Or Benefits For Reconstructive Surgery After Mastectomy- Enrollment

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

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

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

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

If any person covered by this plan has questions concerning the above, please call Bright Health at (844) 926-4524, or write us at P.O. Box 1357, Portland, ME 04104.

Coverage And/Or Benefits For Reconstructive Surgery After Mastectomy- Annual

Your contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

Examinations For Detection Of Prostate Cancer

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

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

If any person covered by this plan has questions concerning the above, please call Bright Health at (844) 926-4524, or write us at P.O. Box 1357, Portland, ME 04104.

Inpatient Stay Following Birth Of A Child

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

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

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

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

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

If any person covered by this plan has questions concerning the above, please call Bright Health at (844) 926-4524, or write us at P.O. Box 1357, Portland, ME 04104.

Coverage For Tests For Detection Of Colorectal Cancer

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

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

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

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

If any person covered by this plan has questions concerning the above, please call Bright Health at (844) 926-4524, or write us at P.O. Box 1357, Portland, ME 04104.

Coverage Of Tests For Detection Of Human Papillomavirus, Ovarian Cancer, And Cervical Cancer

Coverage is provided for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer.

Coverage required under this section includes, at a minimum, a CA 125 blood test and, at a minimum a conventional Pap smear screening or a screening using liquid- based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus; and any other test or screening approved by the FDA for the detection of ovarian cancer.

Bright HealthCare Insurance Company of Texas Service Area Map
List of Counties: Brazoria, Collins, Dallas, Denton, Fort Bend, Galveston, Harris, Hays, Montgomery, Parker, Tarrant, Travis, and Williamson.

Bright Health - Texas Service Area

Texas Service Area

April 7, 2022 Service Areas

Target Counties For Filing - Current
Target Counties For Filing – Proposed

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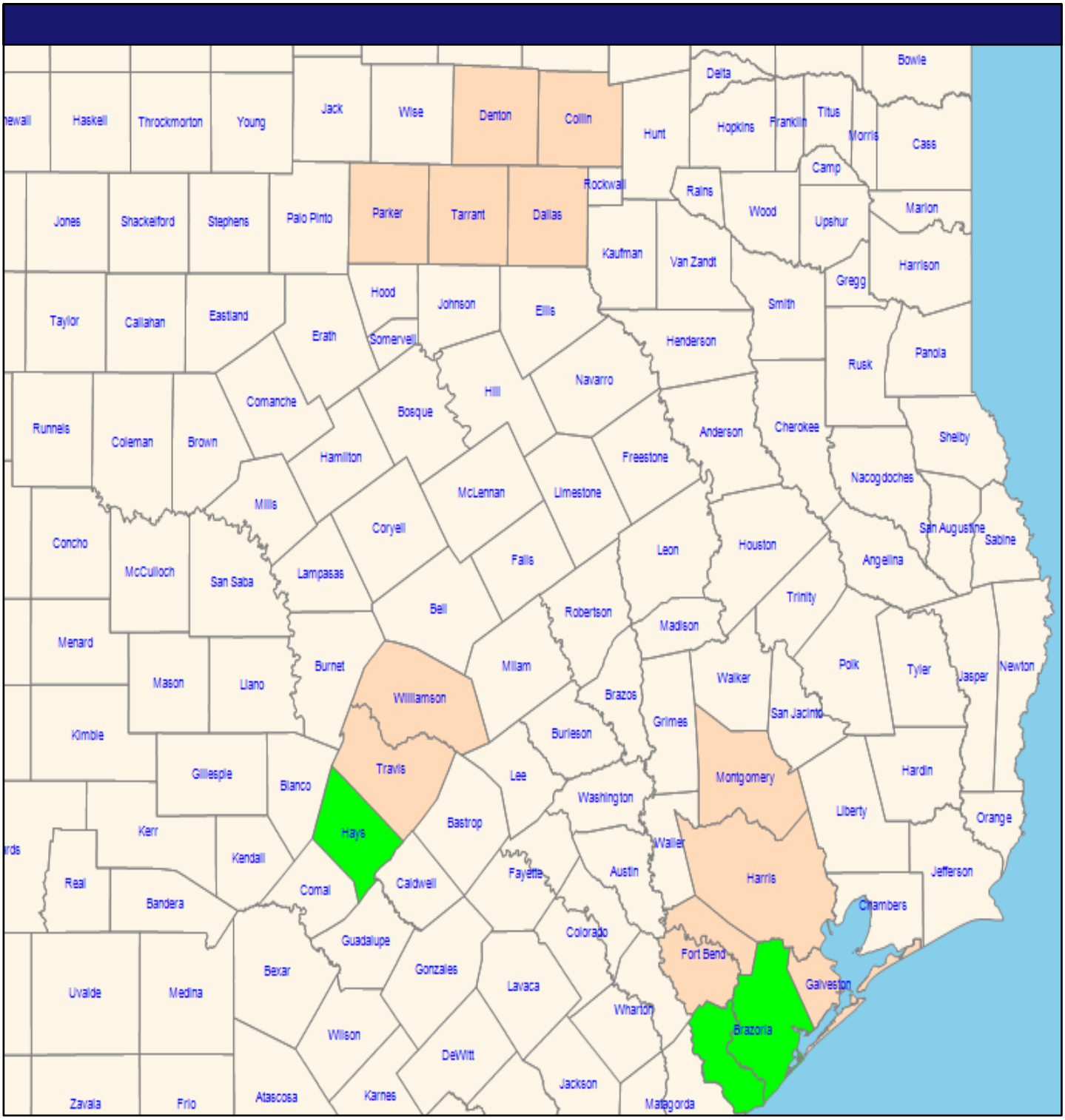

Bright HealthCare

MEMBER HANDBOOK

THIS IS A HEALTH MAINTENANCE ORGANIZATION ("HMO") PLAN

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

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

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

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

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

IF YOU HAVE QUESTIONS ABOUT YOUR PLAN
If You have questions about Your coverage, need assistance resolving a complaint, or need other assistance, please contact Bright HealthCare Member Services at (844) 926-4524, TTY: 711; or visit our website at www.brighthealthplan.com.

TO SEND US CLAIMS OR OTHER WRITTEN CORRESPONDENCE, MAIL TO:

Bright HealthCare
P.O. Box 1357
Portland, ME 04104

READ YOUR EVIDENCE OF COVERAGE
This Member Handbook does not explain all benefits in detail. For a complete explanation of Your benefits, You should read Your entire Evidence of Coverage (EOC), *Schedule of Benefits and Summary of Benefits and Coverage*.

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

MAJOR MEDICAL EXPENSE COVERAGE
Your plan is designed to provide coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for Essential Health Benefits as outlined in the Covered Health Services section below. Covered Health Services are subject to any Deductibles, Copayments, or other limitations that may be set forth in Your EOC.

ATTENTION FEMALE ENROLLEES: You have the right to select and visit an obstetrician-gynecologist (OB-GYN) without first obtaining a referral from your PCP. Bright HealthCare has opted not to limit your selection of an OB-GYN to your PCP's network. You are not required to select an OB-GYN. You may elect to receive your OB-GYN services from your PCP.

COVERED HEALTH SERVICES

We provide coverage for Essential Health Benefits according to the provisions described in Your EOC and as shown in Your Schedule of Benefits. Essential Health Benefits do not have annual or lifetime dollar limitations. Essential Health Benefits must be received from In-Network Providers and must be Medically Necessary.

The following is a list of required Essential Health Benefits which are Covered Health Services under this Plan. The benefits are listed below but are described in detail in Your Evidence of Coverage. Please read Your EOC*, Schedule of Benefits, and Summary of Benefits and Coverage* for a complete explanation of exclusions.

Ambulatory Services

- Accident Related Dental Services
- Physician Services for Sickness and Injury
- Chemotherapy Services
- Radiation Services
- Dialysis Services

Emergency Health Services

- Facility charges, supplies, and all professional services required to stabilize Your condition and/or initiate treatment, including observation
- Professional Services including services rendered by the Emergency room Physicians, consulting Physicians, pathologists, radiologists, and anesthesiologists
- Emergency air or ground transportation

Hospitalizations

- Hospital and Free-Standing Facility Services
- Physician Fees for Medical and Surgical Services
- Chemotherapy Services
- Radiation Services
- Dialysis Services

Note: If You are admitted to an inpatient facility (for example, a hospital or skilled nursing facility), a physician other than the primary care physician may direct and oversee Your care.

Pregnancy – Maternity Services

- Prenatal care and postnatal care and newborn services when the baby is added to the EOC • Hospital delivery services
- Certified nurse midwife services
- Services related to complications of pregnancy
- Breastfeeding and lactation support

Mental Health and Substance Abuse - Inpatient and Outpatient Services

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

Prescription Drugs
The Prescription Drug benefit includes coverage for the following drug tiers:

-
- Tier 1: Preventive Medications
- Tier 2: Preferred Generic Medications
- Tier 3: Non-Preferred Generic Medications; Preferred Brand Name Medications
- Tier 4: Non-Preferred Generic Medications; Non-Preferred Brand Name Medications
- Tier 5: Specialty Medications, Formulary Exceptions
- Tier 6: $0 Generic Drugs. This tier is designated for a specific list of generic drugs for certain plans. Not all generic drugs will fall under this tier.

- Formulary List:

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

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

  You may view the Formulary at Our website www.brighthealthplan.com or contact Our Pharmacy Member Services at the number listed on Your ID Card to request a copy.

Habilitative and Rehabilitative Services
- Outpatient Habilitative Speech, Physical and Occupational therapies
- Durable Medical Equipment
- Home Health Care • Hospice Care
- Outpatient Rehabilitative Speech, Physical, Occupational, Cardiac and Pulmonary therapies
- Skilled Nursing
- Prosthetic Devices

Lab, X-Ray, and Diagnostic Services - Outpatient
- Laboratory and pathology
- X-rays and radiology services performed for diagnostic purposes
- Ultrasound
- High Tech Diagnostic Imaging such as CT scans, PET scans, MRI, MRA
- Nuclear Medicine

Preventive and Wellness Services
- Preventive health care services as recommended by the U.S. Preventive Services Task Force
- Immunizations as recommended by the Centers for Disease Control
- Birth Control and contraceptives
- Child Health Supervision Services

Pediatric Dental Care for Enrolled Children under age 19
- Diagnostic and preventive procedures
- Basic restorative services, which must include
- Oral surgery, consisting of extractions
- Endodontics
- Medically Necessary orthodontia and Medically Necessary prosthodontics

Pediatric Vision Care for Enrolled Children under age 19

- Annual routine vision examination
- Eyeglasses including standard frames and standard lenses or contact lenses

RECEIVING EMERGENCY CARE FROM NETWORK PROVIDERS OR NETWORK FACILITIES

When receiving Medically Necessary Emergency Health Services") from a Participating or -In-Network Facility, You will be responsible for Your In-Network Copayment, or Percentage Copayment amounts as indicated in Your Schedule of Benefits.

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

When receiving emergency care that qualifies as Emergency Health Services from a Non-Network Provider in a Non-Network facility, payment from the Plan, unless otherwise permitted by law, will be the greater of : • The median amount negotiated with In-Network Providers for the emergency service; • Usual, Customary and Reasonable rate based on the geographic region; or.

- The amount that would be paid under original Medicare fee-for-service for the Emergency Health Services.

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

RECEIVING NON-EMERGENT CARE FROM NON-NETWORK PROVIDERS

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

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

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

These Non-Network Providers may send You a balance-bill, which is a bill for the difference between the amount We pay the provider and the provider's billed charges. If You receive a balance-bill You should contact Us at (855) 827-4448. You may also contact the Consumer Protection Division of the Texas Department of Insurance at (800) 252-3439 with complaints regarding payment.

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

BENEFIT DESCRIPTION

Deductible (NOTE: Deductibles apply only to Consumer Choice health benefit plans)
A Deductible is the amount that You must pay before We pay any benefits for Covered Health Services. The Deductible amount does not include Percentage Copayment or Copayment amounts, or non-covered charges. [High Deductible Health Plans (HDHPs) have higher deductibles than most plans. Participation in a High Deductible Health Plan qualifies you to open and contribute money to a Health Savings Account (HSA), which is designated for medical expenses. These plans and savings accounts are regulated by the Internal Revenue Service and there are specific rules about how much money you are allowed to contribute to your HSA each year. For more information regarding HDHPs and/or HSAs, please visit www.irs.gov.]

Copayment
A Copayment is a specific dollar amount that You must pay for certain Covered Health Services. Copayments are limited to 50 percent of the total cost of services provided and, in any calendar year, may not exceed a total of 200 percent of the total annual premium cost which is required to be paid by or on behalf of that Covered Person.

Percentage Copayment
Percentage Copayment is a percentage of charges for Covered Health Services that must be paid by You. Percentage Copayment amounts are paid after the Deductible has been met.

Maximum Out-of-Pocket
The Maximum Out-of-Pocket is the maximum dollar amount that You pay in combined Deductible, Copayment, and Percentage Copayment amounts per Calendar Year. All Deductible, Copayment, and Percentage Copayment payments for In-Network Covered Health Services will apply to Your Maximum Out-of-Pocket amount. Once Your Maximum Out- of-Pocket amount has been met, You will have no further obligation to pay Deductible, Copayment, or Percentage Copayment amounts for In- Network Covered Health Services for the remainder of the Calendar Year. Payments to Non-Network Providers or Non-Network Facilities for charges that exceed Usual and Customary reimbursement do not apply to Your Maximum Out-of-Pocket. For EOCs that provide coverage to two (2) or more people, each person's Individual Maximum Out-of-Pocket applies to the Family Maximum Out-of-Pocket. Once a Covered Person has met their Maximum Out-of-Pocket, In-Network Covered Health 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, In-Network Covered Health Services for the family will be paid at 100%.

Please refer to Your EOC, *Schedule of Benefits, and Summary of Benefits of Coverage*, and for Your specific Deductible, Copayment, Percentage Copayment, and Maximum Out-of-Pocket amounts (including Family Maximum Out-of-Pocket, if applicable).

LIMITATIONS
Some Covered Health Services are limited in the number or duration of services covered. Please refer to Your *Schedule of Benefits, Summary of Benefits and Coverage, and EOC* for these benefit limitations.

EXCLUDED SERVICES
The following list is a summary of the exclusions under Your Plan. Please read Your *EOC, Summary of Benefits and Coverage, and Schedule of Benefits* for a complete explanation of exclusions.

- Administrative services
- Aids or devices that assist with non-verbal communications.
- Alternative Treatments
- Ambulance services that are not Medically Necessary.
- 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.
- Autopsy, except as may be reasonably required by Us at Our own expense.
- Bariatric surgery or weight loss surgery with the purpose of decreasing weight
- Biological sera, blood, blood products or plasma.
- Charges for services provided by a stand-by Physician.
- Charges in excess of the Allowed Amount or in excess of any specified limitation.
- Charges unsupported by medical records.
- Claims received by us after 12 months from the date service was rendered, except in the event of legal incapacity or as required by law.

- Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes.
- Court-ordered testing, except for mental health or substance abuse testing or treatment as required by state law.
- Custodial or Domiciliary Care
- Dental care, except as defined under Section 7, Pediatric Dental Care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia) is not covered.
- Devices used specifically as safety items or to affect performance in sports-related activities
- Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics
- Directed Blood Donations are excluded from coverage.
- 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.
- Experimental, Investigational, or Unproven Services
- Financial responsibility for services that an employer or a government agency is required to provide by law.
- Free care.
- Genetic Testing
- Gym fees or memberships.
- Health services and supplies that do not meet the definition of a Covered Health Service
- 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 for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements.
- Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under Your EOC.
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- Health services while on active military duty.
- Hearing Aids, except coverage for the cost of a Medically Necessary hearing aid or cochlear implant and related services and supplies for a covered individual who is 18 years of age or younger.
- Human Growth Hormone prescribed to adults for any reason.
- Infant formula and donor breast milk.
- Infertility & Reproductive Services and medications
- Inpatient stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- Long-term care/Nursing home care
- Long-term (more than 30 days) storage of products such as cryopreservation of tissue, blood, and blood products.
- Marijuana, including but not limited to medical marijuana for any reason.
- Medical services and procedures that are not legal.
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
- Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Medical supplies and disposable supplies, unless provided through Home Health Care
- Medications available as bulk powder only.
- Medications dispensed for the purpose of appetite suppression or weight loss.
- Medications for which the condition or services are excluded under Your the EOC.
- Medications not approved by the FDA
- Medication prescribed for the treatment of hair loss • Medications prescribed solely for cosmetic purposes.
- Medications used to treat Erectile Dysfunction.
- Medications which are labeled or deemed Investigational or Experimental, including regimens that are unproven.
- Missed and canceled appointments.
- Multi-disciplinary pain management programs provided on an inpatient basis
- Neurobiological Disorders
- Non-Prescription Medications (medications that do not require a prescription), unless specifically included as covered elsewhere in this document, or mandated by Law.
- Non-Network Health services provided in a foreign country, except as required for Emergency Health Services.
- Nutritional Counseling, except when provided as part of a diabetes self-management training program.
- Off-label use of medications unless required by Law, then allowed in accordance with Law.
- Oral appliances to treat sleep apnea or snoring

- Orthotic appliances that straighten or re-shape a body part.
- Personal Care, Comfort, and Convenience Items
- Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under Your EOC
- Physician Assisted Suicide
- Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- Prescribed and non-prescribed outpatient supplies, other than diabetic supplies and inhaler spacers specifically stated as covered.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Prescription Drug Products for any condition, Injury, Sickness, or Mental Illness arising out of, or in the course of, employment for which Benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such Benefits is made or payment or Benefits are received.
- Prescription Drug Products furnished by local, state, or federal government.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms that We determine do not meet the definition of a Covered Health Service.
- Prescription Drug Products obtained through a Non-Network Pharmacy.
- Prescription drugs with a non-prescription equivalent except as described under the Preventive and Wellness Services of the Benefits/Coverage (What is Covered) section of Your EOC.
- Private Duty Nursing, except general nursing care and Private Duty Nursing when Medically Necessary.
- Psychosurgery
- Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage, or adoption.
- Respite care, except as covered under the Hospice Care provision of Your EOC • Rest cures
- Routine dental care for adults.
- Routine foot care
- Preventive Care services rendered by a Non-Network Provider or at a Non-Network Facility.
- Services conducted for purposes of medical research.
- Services of personal care attendants
- Services performed as a result of complications related to or attributable to services that are specifically excluded from coverage under Your EOC.
- Services performed by Non-Network Providers
- Services performed by a provider who is a family member by birth or marriage. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with Your same legal residence.
- Services, other than Emergency Health Services, provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services, other than Emergency Health Services, that are self-directed to a freestanding or Hospital-based diagnostic facility. Services, other than Emergency Health Services, ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital- based diagnostic facility, when that Physician or other provider has not been actively involved in Your medical care prior to ordering the service, or is not actively involved in Your medical care after the service is received.
- Services received as a result of a commission of, or an attempt to commit a felony (whether or not charged) or as a result of being engaged in an illegal act or occupation.
- Services received because of participation in an insurrection, rebellion or riot.
- Services received Outside of Your Coverage Period
- Services received to improve physical appearance
- Services related to judicial or administrative proceedings or orders unless Medically Necessary and for covered services under Your EOC.
- Services required to obtain or maintain a license of any type.
- Services that are not Medically Necessary.
- Speech therapy except as required for habilitative treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorders.
- Temporomandibular Joint Disorder services
- Topical medications for the treatment of onychomycosis of the toenails.
- Transplant services that are not performed at a Designated Facility.

- Travel or transportation expenses, even though prescribed by a Physician, except as described in the Transplant provision of You EOC.
- Unit-dose or re-packaged medications, or costs related to re-packaging of available covered medications.
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury, dislocation, tumors, orthognathic surgery, jaw alignment, or cancer.
- Virtual colonoscopy including CT colonography and capsule endoscopy and colonography
- Virtual coronary angiography and coronary calcium scans
- Vision Services except as covered under Pediatric Vision Services.
- Vitamins
- Voluntary or elective medical or surgical abortions and any related services, drugs or supplies. This exclusion shall not apply to any abortion performed due to a medical emergency. For purposes of this exception, "medical emergency" means a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the Covered Person in danger of death or serious risk of substantial impairment of a major bodily function unless an abortion is performed.
- Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work)

PRIOR-AUTHORIZATION

Pre-authorization is the process of reviewing a request for health care services to determine that they are medically necessary. Pre-authorization is not required for PCP visits, emergency services, urgent care center or after-hours clinic. Pre-authorization is required for hospital care, surgical procedures and certain outpatient services. Please refer to Your *EOC* and *Schedule of Benefits* to see which services require Prior-Authorization. Prior-Authorization does not guarantee We will pay for the services if the physician or provider materially misrepresented or substantially failed to perform the proposed services.

Who is responsible for obtaining Prior-Authorization?

If You are receiving care from an In-Network Provider, the In-Network Provider is responsible for obtaining Prior-Authorization before they provide these services to You, unless the Provider is exempt as required by state law. If the In-Network Provider fails to obtain Prior-Authorization and the service is denied, the In-Network Provider 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 Prior-Authorization is obtained. Information regarding services can come from the Non-Network Provider or from You.

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

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

Failure to obtain the Prior-Authorization prior to receiving care may result in services not being covered.

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

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

If You do not obtain the necessary Prior-Authorization prior to receiving services, those services will be denied as not being preauthorized.

Requests for retroactive pre-authorization of services more than 180 days after the date of service will be denied.

Prior-Authorization Renewal

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

Continuity Of Care
(When Your Provider Leaves Our Network)

You may be eligible for the Continuity of Care process when Your Provider leaves Our network and You wish to continue to receive services from that Provider. The Continuity of Care process facilitates continuation of services at In-Network coverage levels for specified medical and behavioral conditions for a defined period of time when your In-Network doctor, hospital, or Provider leaves our Network and there are reasons preventing immediate transfer of care to another Network Provider that they reasonably believe could cause harm to you. Your Provider should notify Us of the request for Continuity of Care within 30 days of your Network Provider leaving our Network.

If you are under the care of a Network Provider at the time such Provider stops participating in the Network and at the time of the Network Provider's termination, the Covered Person has special circumstances. Special circumstances" means a condition such that the treating physician or health care provider reasonably believes that discontinuing care could cause harm to the patient. Special circumstances shall be identified by the treating physician or health care provider, who must request that the patient be permitted to continue treatment under the physician's or provider's care and agree not to seek payment from the patient of any amounts for which the patient would not be responsible if the physician or provider were still an In-Network Provider. Special circumstances include a (1) disability, (2) acute condition, (3) life-threatening illness, or (4) when a person is pregnant and undergoing a course of treatment for the pregnancy or is past the 24th week of pregnancy at the time the Provider leaves Our Network, in which case the member is eligible for this provision through the delivery and post-partum care within the six (6) week period following delivery, (5) when a person is undergoing a course of treatment for a serious and complex condition from the provider or facility, (6) is undergoing a in accordance with the dictates of medical prudence , (7) is undergoing a course of institutional or Inpatient care from the Provider or Facility, (8) is scheduled to undergo non-elective surgery from the Provider, including receipt of postoperative care from such Provider or Facility with respect to such surgery.. We will continue providing coverage for that Provider's services at the In-Network benefit level.

The continuity of coverage under this subsection will not extend for more than ninety (90) days, or more than nine (9) months if the Covered Person has been diagnosed with a terminal illness, beyond the date the physician's or provider's separation or termination from Our Network takes effect.

For information on how to apply for Continuity of Care, contact Bright Health Plan Member Services at the telephone number listed in Section 2 of this EOC and on Your ID card.

You can obtain a listing of Network Providers on Our website, or by contacting the Member Services Department at the telephone number listed in Section 2 of this EOC and on Your ID card. The provider's Network status is subject to change, so always confirm the provider's Network status he provider at the time services are received.

NONDISCRIMINATION NOTICE AND ASSISTANCE WITH COMMUNICATION

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

WHAT TO DO IF YOU HAVE A COMPLAINT

Contact Member Services at the telephone number listed in in Section 2 of your *EOC* and on Your *ID Card.* Member Services representatives are available to take Your call.

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

If the Member Services representative cannot resolve the issue to Your satisfaction over the phone, he/she can help

you prepare and submit a written complaint.

Within five business days of receiving your oral or written complaint, We will send you a letter acknowledging the complaint, together with a description of Our complaint procedures and timeframes. If the complaint was received orally, We send a complaint form that You must fill out and return for prompt resolution.

After receiving Your written complaint or the written complaint form, We will investigate and resolve Your complaint within 30 calendar days. You will receive a response from Us explaining the resolution of the complaint, stating the specific medical and contractual reasons for the resolution, if applicable, the specialization of any provider consulted, and the complaint appeal process. If the complaint concerns an emergency or a denial of continued hospitalization, We shall investigate and resolve the complaint within 1 business day.

We will not engage in retaliatory action against You, a person acting on your behalf, or a physician or provider who has filed a complaint against Us.

COMPLAINT APPEAL
If you are not satisfied with the outcome of Your complaint you may appeal to a complaint appeal panel. Following receipt of your written request for a complaint appeal You may dispute the complaint resolution in person, in writing, by telephone, or by other methods. We will send you an acknowledgement letter no later than five business days after receiving Your written request for appeal. The complaint appeal panel is an advisory committee composed of an equal number of Our staff, physicians or other providers, and other members covered by Us. The complaint appeal panel will not have been involved in the underlying complaint. If you are disputing specialty care, the appeal panel must include a person who is a specialist in the field of care being disputed. Members selected to participate on the complaint appeal panel will not be Our Staff. You will receive a written decision of the complaint appeal within thirty calendar days of Us receiving the written request for appeal.

FILING COMPLAINTS WITH THE TEXAS DEPARTMENT OF INSURANCE
You may also file a complaint with the Texas Department of Insurance if you are not satisfied with Our appeal process:

Texas Department of Insurance Consumer Protection
Section (MC 111-1A)
P.O. Box 149091 Austin, Texas 78714-9091 E-mail
ConsumerProtection@tdi.texas.gov
1.800.252.3439

PLEASE SEE OUR PROVIDER DIRECTORY ON OUR WEBSITE AT WWW.BRIGHTHEALTHPLAN.COM FOR A LIST OF NETWORK PROVIDERS IN THE SERVICE AREA OR CONTACT THE MEMBER SERVICES DEPARTMENT AT THE TELEPHONE NUMBER LISTED ABOVE AND ON YOUR ID CARD FORASSISTANCE.

SERVICE AREA
Your Service Area is an area (based on full or partial counties) where In-Network Covered Health Services are generally available and readily accessible to You and Your covered Dependents. Please refer to Your EOC for specific information about Your Service Area.

Your Service Area Includes:

Counties
Brazoria, Collins, and Dallas Brazoria, Collins, Dallas, Denton, Fort Bend, Galveston, Harris, Hays, Montgomery, Parker, Tarrant, Travis, and Williamson.

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

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