CareSource®

Health Care with Heart

MARKETPLACE PLAN

Evidence of Coverage And Health Insurance Contract

Ohio

NOTICE: IF YOU OR YOUR FAMILY ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DENTISTS, PROVIDERS AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU AND YOUR FAMILY.

Notice: This evidence of coverage is not a Medicare supplement policy. If you are eligible for Medicare, review the "guide to health insurance for people with Medicare" available from the company.

POLMP-OH(2020)

OH-EXCM-1052

READ YOUR POLICY CAREFULLY. This cover sheet provides only a brief outline of some of the important features of your policy. This cover sheet is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. IT IS THEREFORE IMPORTANT THAT YOU READ YOUR POLICY. This policy is a legal contract between you and CareSource.

You are allowed to return this policy within ten (10) days and have a refund of the premium paid if after examination of its content you are not satisified with the policy for any reason.

CareSource is not a member of any guaranty fund, including the Ohio Life and Health Insurance Guaranty Association. In the event of CareSource's insolvency or in the event that CareSource ends operations, you are protected only to the extent that the hold harmless provision required by the Ohio Revised Code section 1751.13 applies to the Health Care Services rendered. This hold harmless provision states that with the exception of an Annual Deductible, Copayment, Coinsurance and Non-Covered Services, Network Providers may not bill you for Covered Services.

If you are receiving a course of treatment from Network Providers when CareSource ends operations or is declared insolvent, Covered Services will continue to be provided by Network Providers as needed to complete any Medically Necessary procedures and follow-up care for that course of treatment. If you are receiving Inpatient Services at a Network Hospital, your coverage for such Inpatient Services will be continued for up to thirty (30) calendar days after CareSource's insolvency or end of operations.

In the event of CareSource's insolvency or end of operations, you may have to pay for Health Care Services you receive from a Non-Network Provider, whether or not CareSource authorized the use of the Non-Network Provider. If you need additional information, call Member Services at 1-800-479-9502.

CareSource

If you, or someone you're helping, have questions about CareSource, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-479-9502 TTY:711.

ARABIC
إذا كان لديك، أو لدى أي شخص تساعده، أية استفسارات بخصوص CareSource، فيحق لك الحصول على مساعدة ومعلومات مجانًا وباللغة التي تتحدث بها. للتحدث إلى أحد المترجمين الفوريين، اتصل على 1-800-479-9502 TTY:711.

AMHARIC
አርስዎ፣ ወይም አርስዎ የሚያግዙት ግለሰብ፣ ስለ CareSource ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ አርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-800-479-9502 TTY:711 ይደውሉ።

BURMESE
CareSource အကြောင်း သင် သို့မဟုတ် သင်အကူအညီပေးနေသူ တစ်စုံတစ်ယောက်က မေးမြန်းလာပါက သင်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ ဘာသာပြန်တစ်ဦးအား စကားပြောဆိုရန် 1-800-479-9502 TTY:711 ကို တွင် နံပါတ်ဖြည့်သွင်းပါ] သို့ ခေါ်ဆိုပါ။

CHINESE
如果您或者您在帮助的人对 CareSource 存有疑问，您有权免费获得以您的语言提供的帮助和信息。 如果您需要与一位翻译交谈，请致电 1-800-479-9502 TTY:711。

CUSHITE – OROMO
Isin yookan namni biraa isin deeggartan CareSource irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-800-479-9502 TTY:711 tiin bilbilaa.

DUTCH
Als u, of iemand die u helpt, vragen heeft over CareSource, hebt u het recht om kosteloos hulp en informatie te ontvangen in uw taal. Als u wilt spreken met een tolk, bel dan naar 1-800-479-9502 TTY:711.

FRENCH (CANADA)
Des questions au sujet de CareSource? Vous ou la personne que vous aidez avez le droit d'obtenir gratuitement du soutien et de l'information dans votre langue. Pour parler à un interprète, veuillez téléphoner au 1-800-479-9502 TTY:711.

GERMAN
Wenn Sie, oder jemand dem Sie helfen, eine Frage zu CareSource haben, haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache Hilfe und Information zu bekommen. Um mit einem Dolmetscher zu sprechen, rufen Sie die Nummer 1-800-479-9502 TTY:711 an.

GUJARATI જો તમે અથવા તમે કોઈને CareSource વિશે પ્રશ્નો હોય તો તમને મદદ અને મફતમાં માહિતી મેળવવાનો અધિકાર છે. તે ખર્ચ વિના તમારી ભાષામાં પ્રાપ્ત કરી શકાય છે. દુભાષિયા સાથે વાત કરવા માટે 1-800-479-9502 TTY:711 પર કૉલ કરો.

HINDI
यदि आपके, या आप जिसकी मदद कर रहे हैं उसके CareSource के बारे में कोई सवाल हैं तो आपके पास बगैर किसी लागत के अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिए से बात करने के लिए कॉल करें, 1-800-479-9502 TTY:711.

ITALIAN
Se Lei, o qualcuno che Lei sta aiutando, ha domande su CareSource, ha il diritto di avere supporto e informazioni nella propria lingua senza alcun costo. Per parlare con un interprete, chiami il 1-800-479-9502 TTY:711.

JAPANESE
ご本人様、または身の回りの方で、CareSource に関するご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます（無償）。通訳をご利用の場合は、1-800-479-9502 TTY:711 にご連絡ください。

KOREAN
귀하 본인이나 귀하께서 돕고 계신 분이 CareSource에 대해 궁금한 점이 있으시면, 원하는 언어로 별도 비용 없이 도움을 받으실 수 있습니다. 통역사가 필요하시면 다음 번호로 전화해 주십시오: 1-800-479-9502 TTY:711.

PENNSYLVANIA DUTCH
Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut CareSource, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-800-479-9502 TTY:711 uffrufe.

RUSSIAN
Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно CareSource, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком, позвоните по номеру 1-800-479-9502 TTY:711.

SPANISH
Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-800-479-9502 TTY:711.

UKRAINIAN
Якщо у вас, чи в особи, котрій ви допомагаєте, виникнуть запитання щодо CareSource, ви маєте право безкоштовно отримати допомогу та інформацію вашою мовою. Щоб замовити перекладача, зателефонуйте за номером 1-800-479-9502 TTY:711.

VIETNAMESE
Nếu bạn hoặc ai đó bạn đang giúp đỡ, có thắc mắc về CareSource, bạn có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, vui lòng gọi số 1-800-479-9502 TTY:711.

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Dear CareSource Member,

Thank you for trusting CareSource as your health plan! CareSource was founded as a non-profit managed care company in 1989. Our mission is to make a difference in peoples' lives by improving their health care. It is the essence of our company and our unwavering dedication to that mission is a hallmark of our success.

We are offering this Plan as a Qualified Health Plan in the Health Insurance Marketplace (the "Marketplace"). We are committed to putting health care coverage within your reach, making it simple to understand and easy to use.

One way we are doing that is through CareSource.com, where you can find tips for healthy living, exercise, diet, and more. You can also learn more about our various health care plans and our network of doctors. We also offer CareSource24®, a nurse advice line available to help you make health care decisions 24 hours a day, 7 days a week.

Thank you for choosing CareSource. We look forward to serving you and your health needs. If you have any questions or concerns about your health care or your coverage under the Plan, please call us at 1-800-479-9502.

Sincerely,

Erhardt H. Preitauer
President and Chief Executive Officer

SECTION 1 – WELCOME

This section includes information on:

- How to contact us;
- How to use this Evidence of Coverage;
- Your responsibilities;
- When your coverage begins;
- Instructions and timeframes for enrolling you and your Dependents; and
- Your eligibility for Benefits under the Plan.

We are pleased to provide you with this Evidence of Individual Coverage and Health Insurance Contract (EOC). This EOC is an important legal document that describes the relationship between you and CareSource. It serves as your contract with CareSource and it describes your rights, responsibilities, and obligations as a Covered Person under the Plan. This EOC also tells you how the Plan works and describes the Covered Services to which you and your Dependents are entitled, any conditions and limits related to Covered Services, the Health Care Services that are not covered by the Plan, and the Annual Deductible, Copayments, and Coinsurance you must pay when you receive Covered Services. We encourage you to review your EOC carefully and refer to it often. Before you go further, go to the next page for an explanation of how to find the meaning of capitalized words you will find in this EOC.

How to Contact Us

How to Contact CareSource:

- Member Services, Benefit inquiries, and other questions: 1-800-479-9502;
- Pharmacy Drug Benefit Related Questions: 1-800-479-9502;
- CareSource24®, our 24-hour nurse advice line: 1-866-206-4240;
- Online assistance: www.CareSource.com/marketplace;
- CareSource mailing address: Attn: Claims Department, P.O. Box 8730, Dayton, Ohio 45401; and
- For information on how to make payments see Section 2: *How the Plan Works*.

Throughout this document, you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call Member Services. It will be our pleasure to assist you. In some areas, we have partnered with industry leading specialists and may refer you to them for further assistance.

For those Covered Persons with limited English proficiency, we will provide, at no cost, oral interpretation and written translation services. Please call Member Services for more information.

How to Use Your Evidence of Coverage

- Read the entire EOC. Then keep it in a safe place for future reference.
- Many of the sections of this EOC are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your EOC and any future Riders/Enhancements or Amendments at www.CareSource.com/marketplace or request printed copies by contacting Member Services.
- CareSource will mail a written copy of your EOC within seven (7) business days of your request.
- Capitalized words in this EOC have special meanings and are defined in Section 13: *Glossary*.

Because this EOC is a legal document, we encourage you to read it and any of its attached Riders/Enhancements and/or Amendments carefully. You are responsible for understanding all provisions of this document, including any Riders/Enhancements or Amendments. Many of the sections of this EOC relate to one another and you may need to read multiple sections to get all of the information you need. When reviewing your EOC, you should read the entire document and pay particular attention to Section 4: *Your Covered Services*, Section 5: *Prescription Drugs*, and Section 6: *What Is Not Covered*. You should also carefully read Section 12: *Other Important Information* to better understand how this EOC and your Benefits work. Please call us if you have questions about the Covered Services available to you. The terms of this EOC will control if there is a conflict between this EOC and any summaries provided to you by us. Please be aware that your Providers do not have a copy of this EOC, and they are not responsible for knowing or communicating your Benefits.

Defined Terms

Because this EOC is part of a legal document, it is important that you understand the information it contains. Certain capitalized words within this EOC have special meanings that are defined in Section 13: *Glossary*. You should refer to Section 13 often as you see capitalized terms in order to have a clearer understanding of your EOC. When we use the words "we," "us," and "our" in this document, we are referring to CareSource. When we use the words "you" and "your" in this EOC, we are referring to you as a Covered Person, or the Responsible Party, as these terms is defined in Section 13: *Glossary*.

Your Responsibilities

Be Enrolled and Pay Required Premiums

Benefits are available to you only if you are enrolled for coverage under the Plan. To be enrolled under the Plan and receive Benefits, your enrollment must be in accordance with the Plan's and the Marketplace's eligibility requirements, as applicable. You must also qualify as a Covered Person. You must also pay any Premiums required by the Marketplace and/or CareSource.

Choose Your Health Care Providers

It is your responsibility to select the Network Providers and Network Pharmacies that will provide your health care. We can assist you to find Network Providers and Network Pharmacies. We will not cover Health Care Services provided by a Non-Network Provider except as described in this EOC. For more information on choosing your Network Providers, please see Section 2: *How the Plan Works, Choose a PCP*.

Your Financial Responsibility

You must pay Copayments, Coinsurance, and the Annual Deductible for most Covered Services. See Section 2: *How the Plan Works* and Section 4: *Covered Services* for further detail on your Copayments, Coinsurance, and Annual Deductible obligations. The exact amount of the Copayments, Coinsurance, and Annual Deductible for which you are responsible is listed in Section 4: *Covered Services* and your Schedule of Benefits.

Pay the Cost of Limited and Excluded Services

You must pay the cost of all Health Care Services and items that exceed the limitations on payment of Benefits or are not Covered Services. Please review Section 6: *What Is Not Covered* to become familiar with the Plan's limitations and Exclusions.

Show Your ID Card

To make sure you receive your full Benefit under the Plan, you should show your ID Card every time you request Health Care Services. If you do not show your ID Card, your Provider may fail to bill us for the Health Care Services delivered. Any resulting delay may mean that you will not receive Benefits under the Plan to which you would otherwise be entitled.

Don't Forget Your ID Card

Remember to show your CareSource ID Card every time you receive Health Care Services from a Network Provider or a Network Pharmacy. If you do not show your ID Card then, a Network Provider or Network Pharmacy has no way of knowing that you are enrolled with CareSource.

The Marketplace

If you are seeking Benefits under this Plan through the Marketplace, the Marketplace is solely responsible for:

- Determining whether you are eligible for Benefits under the Plan;
- The application and enrollment processes; and
- Determining your subsidy level.

Information regarding enrollment options is available from the Marketplace at www.healthcare.gov. Additional information on how to contact the Marketplace is available at www.CareSource.com/marketplace.

Eligibility Requirements

To be eligible for coverage under the Plan through the Marketplace, you and your Dependents must meet all of the Marketplace's eligibility requirements. Eligibility is determined by the Marketplace and not by CareSource. Generally, you will qualify if you:

- Are a citizen of the United States or a lawfully present immigrant;
- Are not incarcerated, other than incarceration pending the disposition of charges; and
- Are a resident of the State of Ohio and reside within the Plan's Service Area.

If you are not seeking coverage through the Marketplace, you and your Dependents must meet all of the Plan's eligibility requirements. Generally, you will qualify if you are a resident of the State of Ohio and reside within the Plan's Service Area.

CareSource or the Marketplace may ask for verification that you are eligible for coverage under the Plan. You must furnish satisfactory proof to the Marketplace and us in order to demonstrate that the conditions above exist and continue to exist. Coverage under this Plan is available to you through no matter what your health condition is.

Dependents who are eligible to participate in the Plan include:

1. Your legally recognized spouse.
2. Your domestic partner.

   To qualify as a domestic partner, you must:

   - Have a serious, committed relationship with the Covered Person;
   - Be financially interdependent;
   - Not be related to the Covered Person in any way that would prohibit legal marriage by state law;
   - Not be legally married to anyone else;
   - Not be a domestic partner of anyone else; and
   - Not be in a relationship that violates state or local laws.
3. Your natural blood related child, step-child, legally adopted child, a child for who you have legal guardianship, including a child placed in your foster care, or your child who is entitled to coverage under this Plan because of a medical child support order whose age is less than the limiting age. A dependent child is eligible for coverage until the end of the Benefit Year in which the child reaches the limiting age of 26.
4. Your dependent child over the age of 26 if that child is incapable of self-sustaining employment by reason of developmental or intellectual disabilities or physical handicap and is primarily dependent upon you for support and maintenance.

Dependent Provisions

You must furnish satisfactory proof, upon our request, that the above conditions continuously exist. If satisfactory proof is not submitted to us, the Dependent's coverage will not continue beyond the last date of eligibility. Your Dependent must be enrolled in the Plan in order to be considered a Covered Person.

We will provide Benefits to your newly added Dependent spouse effective as of the first day of the month following the date the Marketplace or CareSource, as the case may be, has enrolled your Dependent spouse in the Plan.

We will provide Benefits to your newly born Dependent child from the moment of birth for thirty-one (31) days from the child's date of birth. To continue Benefits for a newly born Dependent, you must submit a request to the Marketplace or CareSource, as the case may be, to add the child to your coverage within sixty (60) days and pay any applicable Premium in accordance with the terms of this Plan.

We will provide Benefits to your newly adopted Dependent child from the moment of adoption for thirty-one (31) days. No premium will be charged for the first thirty-one (31) calendar days. To continue Benefits for a newly adopted Dependent, you must submit a request to the Marketplace or CareSource, as the case may be, to add the child to your coverage within sixty (60) days and pay any applicable Premium in accordance with the terms of this Plan.

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date an order is entered granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

We will provide Benefits to your Dependent child for whom you have legal custody or guardianship, including a child placed in your foster care. If you or your spouse is awarded legal custody or guardianship for a child or a child is placed in your foster care, an application to add the child to your coverage must be submitted to the Marketplace or CareSource, as the case may be, within thirty-one (31) calendar days of the date of the filing of the petition for adoption or the filing of the application for appointment of guardianship, or the date the child was placed in your custody. Coverage under the Plan will begin on the date of the filing of the petition for adoption or the filing of the application for appointment of guardianship, or the date the child was placed in your custody.

Unless otherwise provided for in Section 2: *How the Plan Works, Grace Period*, if payment of Premium is not received within sixty (60) days as described above, you will be responsible for the cost of any Health Care Services received on or after the thirty-second (32nd) day of the birth, adoption or the award of legal custody or guardianship for a child, as the case may be.

We will not deny enrollment to your child on the basis that the child was born out of wedlock; that the child is not claimed as a Dependent on your federal tax return; or that the child does not reside in your household or within the Plan's Service Area. If you are required by a court or administrative order to provide health care coverage for your Dependent child and you do not make application to obtain coverage for the child, we will enroll your Dependent child as a Dependent under the Plan upon an application from the other parent or pursuant to a child support order as required by state law and consistent with any applicable Marketplace or Plan rules or

processes. We will not terminate such child's coverage unless we receive satisfactory written evidence that either the court or administrative order is no longer in effect or the child is or will be enrolled under comparable health care coverage provided by another health insurer, which coverage will take effect not later than the effective date of termination of this Plan. Please see Section 9: *Coordination of Benefits* for additional information.

Application and Enrollment for CareSource

To apply for coverage or to add coverage for a Dependent under the Plan through the Marketplace, you must apply online at enroll.caresource.com or at https://www.healthcare.gov/. You can find a link to the Marketplace website at www.CareSource.com/marketplace. You can find more information on the Marketplace website about eligibility criteria. You can also get help with your enrollment into the Plan by contacting Member Services.

To apply for coverage or to add coverage for a Dependent under the Plan that is not sold through the Marketplace, please call Member Services. Member Services will assist you with your enrollment into the Plan.

You will be asked to verify existing information about you or give proof when requested. Proof of eligibility may include, but not be limited to, age, residence, income, marital status, and employment.

Confirmation of Eligibility

If you are eligible for coverage under the Plan through the Marketplace, then the Marketplace will confirm your eligibility through the website application process or some other form of written communication. The Marketplace will tell you the Premium you must pay to enroll in the Plan as well as other important information about enrolling in the Plan.

If you are eligible for coverage under the Plan outside of the Marketplace, then we will confirm your eligibility in writing. We will tell you the Premium that you must pay to enroll in the Plan as well as other important information about enrolling in the Plan.

We may not refuse to enroll you in the Plan because of your health condition.

Annual Eligibility Determinations

You must enroll in the Marketplace or the Plan, as the case may be, every year. We may need information from you for this process.

Enrollment Date

If you enroll in the Plan through the Marketplace, then the Marketplace will use the information you provide when you enroll to determine the date that your coverage under the Plan is effective. The Marketplace will then advise us of such effective date. If you do not enroll in the Plan through the Marketplace, we will enroll you and determine the date that your coverage under the Plan is effective.

Ineligibility and Your Right to Appeal Eligibility Decisions

If you or your Dependent seek coverage through the Marketplace and the Marketplace determines that you or your Dependent is not eligible for the Plan, the Marketplace will notify you. The Marketplace will give you information on other plans that may be available to you. It will explain how you can appeal any decision made by the Marketplace. You also have the right to appeal to

the Marketplace if you disagree with the calculation of any subsidy amount. To appeal, you will need to request a hearing.

If you or your Dependent seek coverage directly through CareSource (and not the Marketplace) and we determine that you or your Dependent is not eligible for the Plan, we will notify you. You have the right to appeal such decision if you disagree. Your appeal rights are described in Section 8: *Complaint Process, Claims Procedures, and Adverse Benefit Determination Appeals.*

Availability of Benefits After Enrollment in the Plan

When the Marketplace or CareSource, as the case may be, enrolls you in the Plan and your payment sufficient to Effectuate your coverage has been received, we will provide coverage for the Covered Services to you on and after your coverage effective date.

Change in Eligibility Status or Personal Information

You must tell CareSource and the Marketplace (at the time of the event) if:

- You become pregnant;
- You have a baby;
- Your address or phone number changes;
- Your immigration status changes;
- Your income changes;
- Your marital status changes; or
- A Dependent reaches the limiting age.

We and the Marketplace must be notified of these changes within sixty (60) days. These changes may affect the amount you pay. All notices must be in writing and on approved forms or as otherwise required by the Marketplace or us, as the case may be.

A Covered Person's coverage under the Plan terminates on the date such person ceases to be eligible for coverage. Failure to notify the Marketplace or us of any person no longer eligible for coverage will not obligate us to provide such coverage. Acceptance of payments for persons no longer eligible for coverage will not obligate us to pay for Health Care Services.

Open Enrollment

We will hold open enrollment every year during the open enrollment period designated by the Marketplace. If you are enrolled through the Marketplace, CareSource and Marketplace will give you information about the open enrollment process. You cannot choose another qualified health plan once you have enrolled unless (1) you are still within the annual open enrollment period; or (2) you qualify for a special enrollment period.

Special Enrollment

A special enrollment period is a period during which a person who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, coverage through the Plan,

outside of an annual open enrollment period. The length of a special enrollment period is sixty (60) calendar days from the date of a triggering event unless specifically stated otherwise.

Special enrollment periods for qualifying events or changes in eligibility will be provided for individuals who enroll in the Plan through the Marketplace and for individuals who enroll directly with CareSource as required by applicable federal and state law.

Special enrollment periods for individuals who enroll in the Plan through the Marketplace and for individuals who enroll directly with CareSource include the following:

1. Loss of minimum essential coverage due circumstances such as: (i) loss of a job, (ii) voluntarily quitting a job, (iii) divorce or legal separation, (iv) no longer residing in your plan's service area, (v) no longer a Dependent, and (vi) loss of coverage under parent's plan among other circumstances;

2. Enrollment in any non-calendar year group health plan or individual health insurance coverage;

3. Loss of pregnancy related coverage or loss of pregnancy related services provided through the Children's Health Insurance Program "unborn child" option;

4. Loss of Medicaid coverage;

5. Gaining or becoming a Dependent due to marriage, birth, adoption or placement for adoption, placement in foster care, or through child support order or other court order;

6. Enrollment or non-enrollment in a Qualified Health Plan or other health plan that was unintentional, inadvertent, or erroneous and is the result of an error, misrepresentation, misconduct or inaction or the Marketplace or other entity providing enrollment assistance or conducting enrollment services;

7. A Qualified Health Plan or other health plan violates a material provision of its contract with you;

8. Gaining access to new Qualified Health Plans or other health plan as a result of a permanent move;

9. Victim of domestic abuse or spousal abandonment or is a Dependent of a victim of domestic abuse or spousal abandonment; or

10. Being determined ineligible for Medicaid or the Children's Health Insurance Program.

In addition to the above special enrollment periods, individuals who enroll in the Plan through the Marketplace are eligible for the following special enrollment periods:

1. Release from incarceration;

2. Newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or a change in eligibility for cost-sharing reductions;

3. An individual gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603), may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one (1) time per month or an individual is or becomes a Dependent of an Indian, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one (1) time per month at the same time as the Indian;

4. An individual or their Dependents demonstrates to the Marketplace, the individual meets other exceptional circumstances as the Marketplace may provide;

5. An individual or their Dependents demonstrates to the Marketplace that a material error related to plan benefits, service area, or premium influenced individual to purchase a Qualified Health Plan through the Marketplace; or

6. At the option of the Marketplace, an individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a Qualified Health Plan through the Marketplace following termination of Marketplace enrollment due to a failure to verify such status within the specified time period or is under 100 percent of the Federal poverty level and did not enroll in coverage while waiting for the Marketplace to verify his or her citizenship, status as a national, or lawful presence.

7. An individual gains access to an Individual Coverage HRA or is provided with a qualified small employer health reimbursement arrangement (QSEHRA).

SECTION 2 – HOW THE PLAN WORKS

This section includes information on:

- Benefits;
- Your Financial Obligations;
- Your PCP;
- Specialty Care; and
- Authorization Requirements.

Benefits

The Service Area

The Service Area is the geographical area within which we have developed our Network of Providers. Please visit our website for a map of the Plan's Service Area. The Plan is available to you if you live in the Service Area. If you plan to move out of the Service Area, please contact Member Services.

Out of Service Area Dependent Child Coverage

Please note that we will provide coverage, in accordance with the terms of this EOC, for a Dependent child who lives outside of the Service Area if a court order requires that you provide health care coverage to such Dependent child.

Benefits for Covered Services will be provided, in accordance with the terms of the EOC, for enrolled Dependent children who reside outside the Service Area due to such child attending an out of Service Area accredited public or private institution of higher education or residing with your former spouse.

Network Providers

We arrange for Providers to participate in our Network. Because of the importance of knowing whether Benefits are available to you when you use a Provider, you need to verify a Provider's status as a Network Provider by either calling Member Services at the toll-free telephone number on your ID Card or by logging onto our website.

NOTE: Network Providers are subject to change. Network Providers may also limit the number of patients they will accept and have other limitations and restrictions. There is not a guarantee or assurance that you will be able to receive Health Care Services from any certain Network Provider or other Provider during the Benefit Year.

Looking for a Network Provider?

The directory of our Network Providers, called "Find A Doctor," is on our website at CareSource.com/marketplace. A printed directory may be provided to you free of charge. Find A Doctor is updated at least monthly.

Covered Services From Network Providers

We provide Benefits when you receive Covered Services from Network Providers. In order to receive Benefits for Covered Services, you must choose a Network Provider to provide your Health Care Services.

Claims for Physician services provided in a Facility that is a Network Provider by either an anesthesiologist, Emergency Room Physician, consulting Physician, pathologist, or radiologist, whether or not a Network Provider, will be processed as if such services were rendered by a Network Provider.

Services Provided by Non-Network Providers

Health Care Services you receive from Non-Network Providers are not Covered Services unless:

- A Non-Network Provider renders Emergency Health Care Services to you;
- You receive Urgent Care Services while you are temporarily outside the Service Area;
- There is a specific situation involving the continuity of your health care, as explained below in this Section 2;
- You receive Health Care Services from a Non-Network Provider (such as an anesthesiologist or radiologist) while you are in a Hospital or other Facility that is a Network Provider, as explained above; or
- The Health Care Services you need are Covered Services under the Plan and not available from a Network Provider or Facility. In this case, you, your PCP or Network Provider must obtain our Prior Authorization.

NOTE: In the situations provided above, if you receive Health Care Services from a Non-Network Provider, then the Health Care Services will be Covered Services and provided at no greater cost than if you had obtained the Covered Services from a Network Provider.

What You Must Pay

Premium Payments

Your monthly payments may be paid online at www.CareSource.com/marketplace, by phone by calling 1-800-479-9502, or mailing to CareSource at P.O. Box 630568, Cincinnati, Ohio 45263-0568. We will provide you with other important information on Premium payments. You can also find this information on our website. You will receive a monthly bill for your Premium. Your payment is due by the date stated on the bill. You must pay your Premium when it is due in order for your Benefits to continue. You will not receive Benefits for Covered Services if we do not

receive your Premium payments. We will also accept certain Third Party Payments in accordance with 45 C.F.R. § 156.1250.

Your premium rate is guaranteed for the duration of your Benefit Year, which in certain circumstances may be less than 12 months. We reserve the right to change the Premium annually. You will receive sixty (60) calendar days' notice of any change in the amount of Premium, unless otherwise directed by law or the Marketplace. Notification of change in Premium subsidy levels will be handled by the Marketplace.

If Premium has been paid for any period of time after coverage under the Plan is terminated, we will refund that Premium to you. The refund will be for the period of time after your coverage ends. Any applicable refund will be issued within thirty (30) days of the date the termination is processed, the termination date, or the payment date, whichever is later.

Grace Period

If this Evidence of Coverage has been Effectuated, a Grace Period of three (3) consecutive months shall be granted for the payment of any Premium.

During this three (3) month Grace Period, we shall do all of the following:

1. Pay for Covered Services during the first month of the Grace Period;

2. Recover from you any amounts we have paid for all non-Prescription Drug Claims for Covered Services rendered to you in the second and third months of the Grace Period, or pend such non-Prescription Drug Claims during the second and third months of the Grace Period;

3. Recover from you any amounts we have paid for Claims of all Prescription Drugs you received in the second and third months of the Grace Period, or pend such Prescription Drug Claims during the second and third months of the Grace Period;

4. Notify the United States Department of Health and Human Services of such non-payment if you are receiving advance payments of the premium tax credit through the Marketplace; and

5. Notify Network Providers of the possibility for denied Claims during the second and third months of the Grace Period.

If this EOC has not been Effectuated, then the Grace Period provisions stated above do not apply to you. You are responsible for the costs of Health Care Services you received for any period of time that the policy is not Effectuated.

Note: Depending on how coverage was selected during the open enrollment period or during a special enrollment period, this EOC may be automatically Effectuated.

Annual Deductible

The Annual Deductible is the amount you must pay in a Benefit Year before we will provide Benefits for most Health Care Services. Please refer to your Schedule of Benefits for a detailed listing of those Health Care Services that are subject to the Annual Deductible. Benefits for Preventive Health Care Services and some Prescription drugs are not subject to the Annual Deductible. The amounts you pay toward your Annual Deductible accumulate during the Benefit Year.

Eligible Expenses

Eligible Expenses, generally, are charges for Covered Services (*see* the full definition in the Glossary). For certain Covered Services, we will not pay Eligible Expenses until you have met your Annual Deductible for that Benefit Year.

Coinsurance

Coinsurance is a fixed percentage of Eligible Expenses that you are responsible for paying for certain Covered Services.

Coinsurance - Example

You have met your Annual Deductible. You receive Plan Benefits for Home Health Care Services from a Network Provider. Assume that we pay 80%, you are responsible for paying the other 20%. This 20% amount is your Coinsurance.

Copayment

Copayment is a fixed dollar amount that you are required to pay for certain Covered Services, which is usually paid when you received the service. Copayments may vary based on the type of Health Care Service received.

Annual Out-of-Pocket Maximum

The Annual Out-of-Pocket Maximum is the maximum amount that you will pay each Benefit Year for Covered Services. For a complete definition of Annual Out-of-Pocket Maximum, see Section 13*: Glossary*. After you have met your Annual Out-of-Pocket Maximum for a Benefit Year, we will pay 100% of Eligible Expenses for Covered Services through the end of that Benefit Year. The table below shows what does and does not apply toward your Annual Out-of-Pocket Maximum:

Plan Features	**Applies to the Annual Out-of-Pocket Maximum?**
Copayments	Yes
Payments toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for Non-Covered Services	No

Plan Features	Applies to the Annual Out-of-Pocket Maximum?
Adult Dental or Vision Benefits, if applicable	No

If You Receive a Bill From a Network Provider

With the exception of a Copayment, Coinsurance, or Deductible amount, Network Providers may not bill you for Covered Services. However, Network Providers are permitted to bill you for Non-Covered Services. In addition, you are also still responsible for your Annual Deductible and Coinsurance. Please refer to Section 8: *Complaint Process, Claims Procedures and Adverse Benefit Determination Appeals* if you believe you received a bill that you should not have received.

NOTE: Please refer to Section 2: *How the Plan Works, Services Provided by Non-Networks Providers* for more information on when Non-Network Providers may bill you for Health Care Services you receive, regardless of whether they are Covered Services or Non-Covered Services under the Plan.

CareSource Does Not Pay for All Health Care Services

Benefits are limited to Covered Services. For a definition of Covered Services, see Section 13: *Glossary*. Not all Health Care Services will be covered by us.

Your Primary Care Provider

Choose a PCP

CareSource allows you to choose a Primary Care Provider (PCP) who is a Network Provider. Your Network PCP will work with you to direct your health care. Your PCP will treat you for most of your routine health care needs. If needed, your PCP will send you to other doctors (Specialists) or admit you to the Hospital, though their referral is not required. If you prefer, we will be happy to assist you in selecting your Network PCP. For information on how to select a PCP and for a list of Network PCPs, please contact Member Services or visit our website.

Your PCP can be an individual Physician, Physician group practice, advanced practice nurse, or advanced practice nurse group trained in family medicine (general practice), internal medicine, or pediatrics. You may choose a Network Provider who is a pediatrician to serve as a child's PCP. Sometimes a Specialist may need to be your PCP. If you and/or your Specialist believe that he or she should be your PCP, you should call Member Services.

A woman covered under this Plan may choose a Network Provider who specializes in obstetrical or gynecological care to serve as her PCP. The Plan does not require a woman to obtain Prior Authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a Network Provider who specializes in obstetrics or gynecology. For a list of Network Providers who specialize in obstetrics or gynecology, contact Member Services or visit our website.

NOTE: Network Providers, including PCPs, are subject to change. Network PCPs may also limit the number patients they can accept and have other limitations and restrictions. There is not a guarantee or assurance that you will be able to receive Health Care Services from any certain PCP during the Benefit Year.

Visit Your PCP

It is important that you start to build a good doctor/patient relationship with your PCP as soon as you can. After you enroll in the Plan, we recommend that you visit your PCP if you have not met him or her. You can reach your PCP by calling the PCP's office. Introduce yourself as a new Plan Member and schedule an appointment. This will help you get to know your new PCP. It is important to try to see your PCP within your first thirty (30) calendar days of enrollment. If applicable, you should ask your previous doctor to send your medical records to your new PCP. (Note: Your previous doctor may charge you for copies.) If you have difficulty getting an appointment with or seeing your PCP or any Network Provider, please call CareSource Member Services.

Changing Your PCP

We hope you are happy with the PCP you have chosen, but we know that you may decide to choose a different PCP in the future. If you choose a different PCP, you must choose a PCP who is in the Network. You can call us if you need help choosing another PCP.

Please see *Section 2: How the Plan Works, Continuity of Care* for more information how to obtain Covered Services from Providers who leave the Network.

If You Can't Reach Your PCP

Your PCP or covering Provider is available to provide and refer you for care 24 hours a day. If your PCP cannot take your call right away, always leave a message with the office staff or answering service. You should wait a reasonable amount of time for someone to call you back unless you require Emergency Health Care Services. You do not need to call your PCP before seeking Emergency Health Care Services. If you are unable to reach your PCP or the covering Provider, call Member Services during Business Hours or CareSource24® after or before Business Hours.

Canceling Provider Appointments

If you have to cancel an appointment with your PCP or any Provider, always do so as far in advance of your appointment as possible. Providers may charge you for missed appointments. We do not pay, provide coverage, or reimburse you for any missed appointment charges.

When You Need Specialty Care

If you think you need specialty care, we encourage you to first call your PCP. Your PCP can tell you whether you need specialty care and may refer you to an appropriate Network Specialist.

NOTE: We do not require that you receive a referral before receiving Covered Services from a Network Specialist. The Plan allows you direct access to all Network Specialists. However, before you visit a Network Specialist, we recommend that you check with your PCP or Network Specialist

to make sure that you, your PCP or Network Specialist have obtained any required Prior Authorization from us.

Prior Authorization

Prior Authorization is the process used by us to determine whether those Health Care Services listed on our Prior Authorization List meet evidence based criteria for Medical Necessity and are Covered Services under your Plan prior to the Health Care Service being provided. Your Provider, whether a Network Provider or a Non-Network Provider, is responsible for obtaining Prior Authorization for the Health Care Services described on the Prior Authorization List. Please check with your Provider to ensure that your Provider has obtained Prior Authorization prior to you receiving any Health Care Services listed on the Prior Authorization List. The Prior Authorization List is available by calling Member Services at 1-800-479-9502 or by viewing it on our website at www.CareSource.com/marketplace.

If your Network Provider fails to obtain Prior Authorization from us for Health Care Services as required by us and such Provider renders such Health Care Services to you, the Network Provider shall be responsible for the costs of such Health Care Services and neither Plan nor you will be required to pay for such Health Care Services.

If you receive Health Care Services from a Non-Network Provider, either you or the Non-Network Provider must obtain Prior Authorization. If Prior Authorization is not obtained, you are responsible for making full payment to the Non-Network Provider.

Prior authorization is not required from us before you get Emergency Health Care Services. If you have an Emergency, call 911 or go to the nearest Emergency Room or other appropriate setting.

If you are a woman, you do not need authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a Network Provider who specializes in obstetrics or gynecology; however, the Network Provider may be required to obtain prior authorization for certain Health Care Services. Please ensure that your Provider obtains any necessary prior authorizations.

If we, or a utilization review organization acting on our behalf, authorizes a proposed Health Care Service to be provided by a Network Provider based upon the complete and accurate submission of all necessary information relative to a Covered Person, we will not retroactively deny this authorization if the Network Provider renders the Health Care Service in good faith and pursuant to the authorization and all of the terms and conditions of this EOC and the Network Provider's contract with us.

Retroactive Denial of a Prior Authorization

We will not retroactively deny a Prior Authorization for Health Care Services that is based upon the complete and accurate submission of all necessary information relative to you if the Network Provider renders the Health Care Service in good faith pursuant to the approved Prior Authorization and all the terms and conditions of the Network Provider’s contract with us.

Providers Who Leave the Network

Once the Plan is aware that a PCP or Hospital who you see on a Regular Basis is leaving the Network or there is a change in the PCP's Hospital affiliation, the Plan will provide you written notice within thirty (30) days after the PCP or Hospital leaves the Network or of the change in the PCP's Hospital affiliation takes place. We will pay for Covered Services you receive from your PCP or Hospital between the date the provider leaves the Network and five (5) days after we mail you written notice. The Plan will pay for such Benefits as if the PCP or Hospital is in-Network, and the Plan will calculate any Copayments, Coinsurance or Annual Deductibles at the in-Network rates. Neither PCP nor Hospital is permitted to balance bill; contact the Plan if you receive a bill for other than Copayments, Coinsurance or Annual Deductibles.

You can call us if you need help choosing another PCP. You can also call us if you need help choosing any other Provider who you may need to see on a regular basis.

Continuity of Care

While you are expected to seek Health Care Services from Network Providers, when appropriate, we will manage continuity of care requests for you by coordinating care across the Network to ensure that your care is not disrupted or interrupted. Continuity of care concerns may arise when a Non-Network Provider is treating you when you first enroll in the Plan. In addition, continuity of care issues may arise when a Network Provider is no longer a Provider within our Network or when you are or will be receiving services for which a Prior Authorization was received from another plan or payer.

If your circumstances fall within the provisions identified below, you will be eligible for continuity of care from a Non-Network Provider for the listed period of time.

Continuity of Care for Existing Covered Persons

When a Provider who you see on a regular basis leaves the Network, we will use our good faith efforts to notify you thirty (30) days before the Provider leaves if you enrolled with CareSource through the Marketplace.

If you are enrolled in a QHP on-exchange product and undergoing an Active Course of Treatment with your PCP or a Provider who you see on a regular basis and your PCP or Provider who you see on a regular basis was removed from the Network without cause, then the Plan will offer continuing coverage with that PCP or Provider. Such continuing coverage shall be for a period of up to ninety (90) days from the date that the PCP or Provider left the Network or until your treatment is complete, whichever is shorter. We will pay for such Benefits as if the PCP or Provider is in-Network, and we will calculate any Copayments, Coinsurance or Deductibles at the in-Network rates. However, if you have successfully transitioned to a Network Provider, met or exceeded the Benefit limits under the Plan, or if the treatment is not Medically Necessary, then we may not authorize continuing coverage with that PCP or Provider who you have seen on a regular basis. Your PCP or Provider should contact the Medical Management Department to obtain our Prior Authorization.

If you are a woman in your second or third trimester of Pregnancy and the Network Provider you are seeing in connection with your Pregnancy leaves the Network (for reasons other than Fraud or quality of care), you may continue to receive Covered Services from that Provider through the delivery of your child, immediate postpartum care, and examination within the first six (6) weeks following delivery. Your Provider should contact the Medical Department to obtain our Prior Authorization.

If you have a Terminal Illness, and the Provider you are seeing in connection with your Terminal Illness is no longer participating in the Plan (for reasons other than Fraud or quality of care), you may, with our Prior Authorization, continue to receive coverage for Covered Services provided by that Provider until you no longer need Health Care Services. Please have your Provider contact the Medical Management Department to obtain our Prior Authorization.

NOTE: Please reference Section 11: *When Coverage Ends, Benefits after Termination* for more information on when you are receiving Inpatient Health Care Services in a Hospital and your Benefits under the Plan have been terminated.

Continuity of Care for New Covered Persons

If you are a new Covered Person of the Plan, we will provide coverage for Covered Services provided by your existing Physician or nurse practitioner, if he or she is a Non-Network Provider, as follows:

1. For up to thirty (30) days after your coverage effective date if:

    - The Physician or nurse practitioner does not participate in another Marketplace Qualified Health Plan for which you are eligible through the Marketplace; or
    - The Physician or nurse practitioner is providing you with an Active Course of Treatment or is your PCP.

2. Through your first postpartum visit, if you are a new Covered Person in your second or third trimester of Pregnancy. If you are a woman in your first trimester of Pregnancy when your coverage becomes effective and the Provider you are seeing in connection with your Pregnancy is a non-Network Provider, you must choose a Network Provider in order to receive Benefits.

3. Until death, if you are a new Covered Person with a Terminal Illness.

You must obtain our Prior Authorization before continuing your care with a Non-Network Provider.

Conditions for Coverage of Continuity of Care as Described in this Section

Health Care Services rendered by a Provider who is disenrolled from the Network or a Non-Network Provider as described in this "Continuity of Care" section will only be covered when the Health Care Services would otherwise be Covered Services if provided by a Network Provider under this EOC, and the Provider agrees to:

- Accept payment from the Plan at the rates we pay to Network Providers of the same specialty or sub-specialty;
- Accept such payment as payment in full and not charge you any more than you would have paid if the Provider was a Network Provider;
- Comply with the Plan's quality assurance standards;
- Provide us with necessary medical information related to the care provided; and
- Comply with our policies and procedures including but not limited to procedures regarding referrals, obtaining prior authorization, and providing Covered Services pursuant to a treatment, approved by the Plan.

SECTION 3 – IMPORTANT INFORMATION ON EMERGENCY, URGENT CARE, AND INPATIENT SERVICES

This section includes information on:

- Emergency Health Care Services;
- Urgent Care Services; and
- Inpatient Services.

It is especially important for you to know certain information about your Benefits for Emergency Health Care Services, Urgent Care Services, and Inpatient Services. This section explains those Benefits.

Emergency Health Care Services

Emergency Health Care Services are used to treat an Emergency Medical Condition. We provide Benefits for an Emergency Medical Condition within the United States and abroad.

You do not have to obtain our authorization before you get Emergency Health Care Services. If you have or think you have an Emergency Medical Condition, call 911 or go to the nearest Emergency Room or other appropriate setting. If you are not sure whether you need to go to the Emergency Room, call your PCP or CareSource24®. Your PCP or CareSource24® can talk to you about your medical problem and give you advice on what you should do.

Remember, if you need Emergency Health Care Services:

- You should go to the nearest Emergency Room or other appropriate setting. Be sure to tell the Provider you are a CareSource Member and show the Provider your ID Card.
- If the Provider takes care of your Emergency Medical Condition but thinks that you need other medical care to treat the problem that caused your Emergency Medical Condition, the Provider must call CareSource.
- If you are able, call your PCP as soon as you can to let him or her know that you have an Emergency Medical Condition. If you are unable to call your PCP, have someone call for you.

If the Hospital admits you as an Inpatient, please make sure that CareSource is called within twenty-four (24) hours after your admission or as soon as reasonably possible. Copayments, Coinsurance and your Deductible may apply.

Notice to Your PCP or CareSource Following Emergency Care

If you receive Emergency Health Care Services at an Emergency Room (whether inside or outside the Service Area), but are not admitted to the Hospital, you or someone acting on your behalf must call your PCP or CareSource within forty-eight (48) hours after receiving care or as soon as

reasonably possible. This will allow your PCP to provide or arrange for any follow-up care that you may need.

If you receive Emergency Health Care Services care at an Emergency Room (whether inside or outside the Service Area) and you are admitted as an Inpatient, you or someone acting on your behalf must call your PCP or us within twenty-four (24) hours of your admission or as soon as reasonably possible. This is essential so that your PCP can manage and coordinate your care, arrange for any Medically Necessary transfer, and arrange for any follow-up care you may need. (*Note:* notice by the Provider of Emergency Health Care Services to your PCP or us satisfies your requirement to notify your PCP and us.)

Emergency Health Care Services Received from Non-Network Providers

If you received Emergency Health Care Services from a Non-Network Provider, the Emergency Health Care Services will be Covered Services and provided at no greater cost to you than if you had obtained the Emergency Health Care Services from a Network Provider. Non-Network Providers who render Emergency Health Care Services to you should not be sending you a bill. However, you will still be responsible for any applicable Copayments, Coinsurance, and Annual Deductible. If you receive a bill from a Non-Network Provider for the provision of Emergency Health Care Services, please contact us immediately at the number on your ID Card, and we will help you with the bill.

Transfer

If you have been admitted to a Facility that is a Non-Network Provider after you have received Emergency Health Care Services and your PCP determines that a transfer to another Facility is medically appropriate, you will be transferred to a Facility that is a Network Provider. We will not pay for Inpatient Stay provided in the Facility that is a Non-Network Provider to which you were first admitted after your PCP determined that a transfer is medically appropriate and transfer arrangements have been made for you.

Coverage for Urgent Care Services Outside the Service Area

If you get hurt or sick while temporarily traveling outside the Service Area, we will pay for Covered Services for Urgent Care Services that you receive from Non-Network Providers. Prior to seeking Urgent Care Services, we recommend that you call your PCP for guidance; however, you are not required to do so. You should obtain Urgent Care Services from the nearest and most appropriate health care Provider.

The Plan will not cover the following types of care when you are traveling outside the Service Area:

- Care you could have foreseen needing before leaving the Service Area, including care for chronic medical conditions that require ongoing medical treatment.
- Routine care or preventive care.
- Elective Inpatient Stays or Outpatient surgery that can be safely delayed until you return to the Service Area.

- Follow-up care that can wait until your return to the Service Area.

If you are hospitalized outside the Service Area after you receive Urgent Care Services, you must call your PCP or us within forty-eight (48) hours after admission or as soon as reasonably possible.

Inpatient Hospital Stay

Inpatient Hospital Services

Except in the case of an Emergency Medical Condition, you must always call your PCP first before going to a Hospital. If you need Hospital care, your PCP will refer you to a Network Hospital. In rare instances when the Hospital services you need are not available from any Hospital that is a Network Provider, your PCP may refer you to a Hospital that is a Non-Network Provider after obtaining prior authorization from us.

Charges After Your Discharge from a Hospital

If you choose to stay as an Inpatient after a Physician has scheduled your discharge or determined that further Inpatient Services are no longer Medically Necessary, we will not pay for any of the costs incurred after your scheduled discharge or after Inpatient Services are determined to be no longer Medically Necessary.

SECTION 4 – YOUR COVERED SERVICES

This section includes information on:

- Your Schedule of Benefits, which may be accessed by visiting https://www.caresource.com/plans/marketplace/plan-documents/;
- Your Covered Services; and
- When authorization is required.

This section provides an overview of your Covered Services. For detailed information regarding your Annual Deductible, Coinsurance, Copayments and Annual Out-of-Pocket Maximum, please refer to the *Schedule of Benefits* which is incorporated into, and a part of, this EOC. You should have received a copy of the *Schedule of Benefits.* If there is a conflict between this EOC and the *Schedule of Benefits*, this EOC shall control. Except as specifically provided in this EOC, we do not cover Health Care Services provided by Non-Network Providers.

All Covered Services are subject to the conditions, Exclusions, limitations, terms and provisions of this EOC, including any Riders/Enhancements or Amendments. Covered Services must be Medically Necessary and not Experimental or Investigational. The fact that a Provider may prescribe, order, recommend or approve Health Care Services does not make them Medically Necessary or Covered Services and does not guarantee payment. To receive maximum Benefits for Covered Services, you must follow the instructions outlined in this EOC, including receipt of care from a Network Provider, and obtaining any required prior authorization. Please refer to Section 2: *How the Plan Works – Prior Authorization*. If your Network Provider fails to obtain prior authorization from us for Health Care Services as required by us, and the Network Provider renders such Health Care Services to you, the Network Provider shall be responsible for the costs of such Health Care Services and neither CareSource nor you will be required to pay for such Health Care Services. If you receive Health Care Services from a Non-Network Provider and either you or the Non-Network Provider did not obtain prior authorization for such Health Care Services, you are responsible for making full payment to the Non-Network Provider.

1. AMBULANCE SERVICES

Description

Ambulance Services means transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals.

The Plan provides Benefits for non-Emergency Ambulance Services (either ground or air, as we determine appropriate) between Hospitals and Facilities when the transport is any of the following:

- When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse;

- From a Non-Network Provider to a Network Provider;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost effective acute care Facility;
- From an acute Facility to a sub-acute setting;
- From a Hospital to a Skilled Nursing Facility; and
- From a Hospital or Skilled Nursing Facility to the Covered Person's Home.

The Plan also provides Benefits for Emergency Health Care Services provided by Emergency medical responders at your home or at the scene of an accident, or during transportation by Ambulance Services when Medically Necessary.

Authorization Requirements

Prior Authorization of Ambulance Services is not required for emergency ambulance transportation or for Facility to Facility transfers. All other ambulance transportation requires Prior Authorization. Please check with your Provider to make sure he or she has obtained the necessary Prior Authorization.

Limitations

The Plan does not cover Ambulance Services provided by ambulettes or similar vehicles, including taxi or other means of public transportation.

Ambulance transports must be made to the closest local Facility that can provide you with Covered Services appropriate for your medical condition. If none of these Facilities are in your local area, the Plan will provide Benefits for an Ambulance Transport to the closest Facility outside your local area. Non-Covered Services include trips to a Physician's office or clinic or a morgue or funeral home.

2. BEHAVIORAL HEALTH CARE SERVICES

Description

The Plan provides Benefits for Behavioral Health Care Services as described below.

Inpatient Stays. The Plan provides Benefits for Behavioral Health Care Services you receive during an Inpatient Stay. These services include individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.

Residential Treatment Services. The Plan provides Benefits for Behavioral Health Care Services in a Residential Treatment Program. These Health Care Services can include individual and group psychotherapy, family counseling, nursing services, and pharmacological therapy in a supportive 24-hour community.

Partial Hospitalization. The Plan provides Benefits for Behavioral Health Care Services provided in a partial hospitalization setting with an intensive structured setting providing three (3) or more hours of treatment or programming per day or evening, in a program that is available five (5) days a week. The intensity of services must be similar to Inpatient settings where skilled nursing care and daily psychiatric care are available and treatment is provided by a multidisciplinary team of Behavioral Health Care Services professionals. The Plan also provides Benefits for Substance Use Disorder Treatment programs provided in a partial hospitalization setting.

Intensive Outpatient Services. The Plan provides Benefits for intensive Outpatient Services offered by practice groups or Facilities that provide Behavioral Health Care Services. Intensive Outpatient Services programs are defined as those that provide three (3) hours of treatment per day, and the program is available at least two (2) to three (3) days per week. Intensive Outpatient Services programs may offer group, dialectical behavior therapy, individual, and family therapy.

Other Outpatient Services. The Plan provides Benefits for office-based Behavioral Health Care Services. These include diagnostic evaluation, counseling, psychotherapy, family therapy, psychiatry, and medication evaluation. The services may be provided by a licensed mental health professional.

Authorization Requirements

Your Provider must obtain Prior Authorization from us for all Inpatient Stays and Residential Treatment Programs. The Plan may also require prior authorization for Partial Hospitalization programs, and Intensive Outpatient Services related to Behavioral Health Care Services. All requests for Prior Authorization of opioid use treatment will be treated as an Urgent Review Request. Please confirm that your Provider has obtained the necessary Prior Authorization from us before receiving such services.

Limitations

Coverage for the diagnosis and treatment of a Behavioral Health Disorder will not be subject to any limitations, including Annual Deductibles, Copayment, and Coinsurance provisions that are less favorable than the limitations that apply to a physical Sickness as covered under this EOC.

The following Health Care Services are not Covered Services:

- Custodial Care or Domiciliary Care.
- Supervised living or halfway houses.
- Room and board charges unless the treatment provided meets our Medical Necessity criteria for an Inpatient Stay for your condition.
- Services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

3. COVERED CLINICAL TRIALS

Description

The Plan provides Benefits for routine patient Health Care Services you receive as part of an approved clinical trial provided that such Health Care Services are otherwise Covered Services under the Plan. Approved clinical trial means a clinical trial that (i) is a Phase I, Phase II, Phase III, or Phase IV clinical trial, as set forth in FDA regulations, that is conducted in relation to the prevention of cancer or another life-threatening disease or condition (defined as any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted); and (ii) meets all of the following criteria:

- The purpose of the trial is to test whether the intervention potentially improves your health or the treatment is given with the intention of improving your health, and is not designed simply to test toxicity or disease pathophysiology;
- The trial does one of the following:
  - Tests how to administer a Health Care Service for the treatment of cancer or a life-threatening disease;
  - Tests responses to a Health Care Service for the treatment of cancer or a life threatening disease;
  - Compares the effectiveness of Health Care Services for the treatment of cancer or a life-threatening disease; or
  - Studies new uses of Health Care Services for the treatment of cancer or a life-threatening disease; and
- The trial is approved by one of the following:
  - The National Institutes of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services;
  - The Centers for Disease Control and Prevention, or one of its cooperative groups or centers;
  - The Agency for Health Care Research and Quality, or one of its cooperative groups or centers;
  - The Centers for Medicare and Medicaid Services, or one of its cooperative groups or centers;
  - The United States Food and Drug Administration;
  - The United States Department of Defense; or
  - The United States Department of Veteran's Affairs.

Authorization Requirements

Coverage for clinical trials requires our Prior Authorization. Your Provider must obtain Prior Authorization from us. Please confirm that your Provider has obtained Prior Authorization from us before receiving such Health Care Services.

Limitations

The Plan does not cover the following:

- A Health Care Service that is the subject of the clinical trial or is provided solely to satisfy data collection and analysis needs for the clinical trial that is not used in the direct clinical management of you;
- An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for you, your family members or your companions that are associated with the travel to or from a Facility providing the approved clinical trial;
- A Health Care Service provided by the clinical trial sponsors free of charge to you; and
- A Health Care Service that is eligible for reimbursement by a person other than us, including the sponsor of the clinical trial.

4. DENTAL SERVICES – PEDIATRIC

Description

The Plan provides pediatric dental Benefits for children up to the end of the month in which a child turns nineteen (19) years of age. All Benefits are subject to the definitions, limitations and Exclusions in this EOC and are payable only when they are deemed Medically Necessary for the prevention, diagnosis, care, or treatment of a Covered Service and meet generally accepted dental protocols.

All exams, oral evaluations and treatments such as fluorides and some images are combined under one limitation under the Plan. Periodic oral exams Oral evaluations and Comprehensive oral exams are combined and limited to one exam every six (6) months from the date Covered Services were last rendered.

The Plan provides Benefits for the following pediatric dental services:

- **Dental exam:** Limited to one (1) every six (6) months from the date Covered Services were last rendered.
    - Periodic oral evaluation
    - Limited oral evaluation
    - Comprehensive oral evaluation

- Comprehensive periodontal evaluation

- **Preventive Services:** Preventive Services are part of your Essential Health Benefits and will be covered at no cost to you if provided by a Network Provider. The list below is an example and not wholly inclusive of all Covered Services.
  - Prophylaxis – limited to one (1) examination two (2) times per Benefit Year
  - Topical Fluoride – limited to two (2) every twelve (12) months
  - Sealant - per tooth – limited to one (1) every thirty-six (36) months
  - Space Maintainer - fixed - unilateral
  - Space Maintainer - fixed - bilateral
  - Space Maintainer - removable - unilateral
  - Space Maintainer - removable - bilateral
  - Re-cementation or re-bond space maintainer

- **Diagnostic and Treatment Services:** Minor palliative treatment of pain included in these Covered Services. The list below is an example and not wholly inclusive of all Covered Services.
  - Palliative treatment of dental pain – minor procedure
  - Intraoral complete set of images, including bitewings
  - Intraoral periapical radiographic image(s) – limited to one (1) two (2) times per Benefit Year
  - Bitewing(s) – limited to one (1) two (2) times per Benefit Year
  - Vertical bitewings – seven (7) to eight (8) images – limited to one (1) two (2) times per Benefit Year
  - Panoramic radiographic image – limited to one (1) every sixty (60) months
  - Cephalometric radiographic image
  - Oral / Facial photographic images
  - Interpretation of diagnostic image
  - Diagnostic models

- **Basic Restorative Services:** Covered Services range from fillings to specific types of crowns. The list below is an example and not wholly inclusive of all Covered Services.
  - Amalgam(s) - primary or permanent
  - Resin-based composite(s), anterior
  - Prefabricated porcelain crown – primary tooth – limited to one (1) every sixty (60) months
  - Prefabricated stainless steel crown – primary tooth – limited to one (1) every sixty (60) months
  - Prefabricated stainless steel crown – permanent tooth – limited to one (1) every sixty (60) months

- **Major / Comprehensive Services:** Covered Services include root canals, oral surgery, dentures, bridges endodontic services and periodontal therapy. The list below is an example and not wholly inclusive of all Covered Services.
  - Therapeutic pulpotomy

- Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development
- Pulpal Therapy – anterior tooth – once per tooth
- Periodontal scaling and root planning – four (4) or more teeth per quadrant – limited to one (1) every twenty-four (24) months
- Removal of impacted tooth – soft tissue
- Surgical removal of residual tooth roots (cutting procedure)
- Crown – Porcelain/ceramic substrate - limited to one (1) every sixty (60) months
- Anterior root canal (excluding final restoration)
- Complete and Immediate denture(s) – Limited to one (1) every sixty (60) months
- Removable unilateral partial denture - Limited to one (1) every sixty (60) months
- Gingivectomy or gingivoplasty – four (4) or more teeth – limited to one (1) every thirty-six (36) months
- Complete denture – maxillary – limited to one (1) every sixty (60) months
- Inlay services
- Onlay services – limited to one (1) per tooth every sixty (60) months
- Veneer Repair
- Anterior root canal
- Apexification/recalcification – initial visit through final visit
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy
- Osseous surgery – limited to one (1) every thirty-six (36) months
- Free soft tissue graft – 1st tooth and any additional teeth
- Eposteal Implant - Limited to one (1) every sixty (60) months

- **Orthodontic Services:** The Plan also provides Benefits for Medically Necessary orthodontic services. Comprehensive Medically Necessary orthodontic services are Covered Services for Covered Persons who have a severe handicapping malocclusion related to a medical condition such as:

  - Cleft palate or other congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services;
  - Trauma involving the oral cavity and requiring surgical treatment in addition to orthodontic services; or
  - Skeletal anomaly involving maxillary and/or mandibular structures

  To be considered Medically Necessary (needed to treat, correct or ameliorate a medical defect or condition,) orthodontic services must be an essential part of an overall treatment plan. Establishment of Medical Necessity requires documentation to support the severe handicapping malocclusion and medical condition status. Progress notes, photographs and other relevant supporting documentation may be included as appropriate. Covered Services include:

  - Limited orthodontic treatment of the primary dentition

- Limited orthodontic treatment of the transitional dentition
- Limited orthodontic treatment of the adolescent dentition
- Interceptive orthodontic treatment of the primary dentition
- Interceptive orthodontic treatment of the transitional dentition
- Comprehensive orthodontic treatment of the transitional dentition
- Comprehensive orthodontic treatment of the adolescent dentition
- Removable appliance therapy
- Fixed appliance therapy
- Pre-orthodontic treatment exam to monitor growth and development
- Periodic orthodontic treatment visit (as part of contract)
- Orthodontic retention (removal of appliances, construction and placement of retainer(s)).

Authorization Requirements

You must obtain our Prior Authorization before receiving Medically Necessary orthodontic services.

Limitations

Orthodontic Services provided for dental conditions that are primarily cosmetic or corrective, i.e. used to correct an improper alignment of upper and lower teeth, including crooked or crowded teeth, cross bites, overbites or underbites, in nature or when self-esteem is the primary reason for treatment does not meet the definition of Medical Necessity and are not Covered Services.

Additional Benefits

- The Plan will provide Benefits for Covered Services such as diagnostic consultations, therapeutic drug injections and post-surgical services to treat complication due to unusual circumstances.

- Anesthesia (general and intravenous conscious sedation) will be a Covered Service when Medically Necessary.

Exclusions

Although we may list a specific service as a Benefit, we will not cover it unless we determine it is Medically Necessary for the prevention, diagnosis, care or treatment of a Covered Service.The Plan does not cover the following:

- Local, regional, or trigeminal anesthesia
- Non-intravenous conscious sedation
- Oral Sedation
- Analgesia – Nitrous Oxide
- House/extended care call
- Hospital call

- Case presentation
- Other drugs and/or medicaments
- Behavior Management
- Athletic mouth guard
- Occlusion analysis (mounted case) and adjustments (both limited and complete)
- Enamel microbrasions
- Odontoplasty 1-2 teeth
- External (per tooth/arch) and Internal bleaching (per tooth)
- Sialography
- Oral Pathology lab
- Facial Moulage (sectional and complete)
- Prostheses (Nasal/Nasal Septal, Auricular, Orbital, Facial, Cranial)
- Facial Augmentation implant
- Prostheses Replacements (Nasal/Nasal Septal, Auricular, Orbital, Facial, Cranial)
- Mandibular resection Prosthesis (w and w/out guide flange)
- Obturator Prosthesis (interim)
- Trismus Appliance
- Feeding Aid
- Speech Aid / Speech Aid Prosthesis (modification)
- Palatal Augmentation and Palatal Lift Prosthesis
- Surgical Stent
- Radiation Carrier / Shield or Cone locator
- Commissure Splint
- Surgical Splint
- Adjust maxillofacial prosthetic appliance
- Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments
- Biopsy of oral tissue (hard or soft)
- Harvest of bone for use in autogenous grafting procedures
- Lesion removal, regardless of length or diameter (benign or malignant)
- Destruction of lesion
- Removal of foreign body
- Removal of reaction producing the foreign body
- Partial Ostectomy
- Maxillary Sinusotomy
- Surgical Reductions (Upper/Lower open, Upper/Lower closed, simple/compound, Alveolus, Facial bones)
- Malar and/or zygomatic arch (open or closed)
- Alveolus (open/closed red, compound – stabilization of teeth)
- TMJ services (open, closed reduction or manipulation), except as otherwise stated in this EOC.
- Condylectomy
- Surgical discectomoy
- Disc repair

- Synovectomy
- Myotomy
- Joint reconstruction
- Arthrotomy
- Arthroplasty
- Arthrocentesis
- Arthroscopy (non-arthroscopic, w or w/o biopsy, adhesions, disc, synovectomy, discectomy and debridement)
- Sutures (complicated up to 5 cm and greater than 5 cm)
- Skin graft
- Osteoplasty deformities
- Osteotomy (lower rami, segmented, body of mandible)
- Lefort I, II, or III
- Bone graft (mandible or face)
- Repair of maxillofacial soft or hard tissue
- Sialolithotomy
- Excision of salivary gland
- Sialodochoplasty
- Closure of salivary fistula
- Emergency tracheotomy
- Coronoidectomy
- Synthetic Graft
- Implant lower for augmentation purposes
- Viral culture
- Caries test
- Stains for microorganisms
- Electron microscopy
- Consultation on slides preparation
- Nutritional counseling
- Tobacco counseling
- Oral Hygiene Instruction
- Surgical replacement screw retained
- Sinus Augmentation
- Intraoral placement of a fixation device
- Gold Foil
- Coping
- Canal preparation
- Splinting
- Interim dentures (complete or partial)
- Fluoride Gel Carrier
- Provisional retainer Crown
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliance;

- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation and restoration for misalignment of teeth.
- Health Care Services not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, the Plan will pay for eligible Covered Services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Health Care Services which are Experimental or Investigational Services;
- Health Care Services which are for any Sickness or Injury which occurs in the course of employment if a Benefit is available, in whole or in part, under the provision of any law or regulation or any government unit. This Exclusion applies whether or not you claim the Benefits;
- Health Care Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;
- Health Care Services performed prior to your effective date of coverage;
- Health Care Services incurred after the termination date of your coverage unless otherwise indicated;
- Health Care Services which are not Medically Necessary or which do not meet generally accepted standards of dental practice.
- Health Care Services resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any Health Care Services that are considered strictly Cosmetic Procedures including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Health Care Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction, except as otherwise stated in this EOC;
- Office infection control charges;
- Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
- State or territorial taxes on dental Health Care Services performed;
- Health Care Services submitted by a dentist, which are for the same Health Care Services performed on the same date for the same Covered Person by another dentist;
- Health Care Services provided free of charge by any governmental unit, except where this Exclusion is prohibited by law;
- Those for which the Covered Person would have no obligation to pay in the absence of the Benefits provided under the Plan;
- Health Care Services which are for specialized procedures and techniques;
- Health Care Services performed by a dentist who is compensated by a Facility for similar Covered Services performed for Covered Persons;
- Duplicate, provisional and temporary devices, appliances, and Health Care Services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;

- Health Care Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Gold foil restorations;
- Hospital costs or any additional fees that the dentist or Hospital charges for Health Care Services at the Hospital (Inpatient or Outpatient);
- Charges by the Provider for completing dental forms;
- Adjustment of a denture or bridgework which is made within six (6) months after installation by the same dentist who installed it;
- Use of material or home health aides to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Cone Beam Imaging and Cone Beam MRI procedures;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Orthodontic care for Dependent children beginning the month following attainment of age nineteen (19);
- Fabrication of athletic mouth guard;
- Internal and external bleaching;
- Topical medicament center;
- When two or more Health Care Services are submitted and the Health Care Services are considered part of the same Health Care Service to one another. We will pay the most comprehensive Health Care Services (the service that includes the other non-benefited service) as determined by us.
- When two or more Health Care Services are submitted on the same day and the Health Care Services are considered mutually exclusive (when one service contradicts the need for the other service). We will pay for the service that represents the final Health Care Services as determined by us.
- All Health Care Services rendered by a Non-Network Provider, unless specifically authorized by us. The Covered Person may be responsible for all remaining charges that exceed the allowable maximum.

5. DENTAL SERVICES

Description

Related to Accidental Injury: The Plan provides Benefits for Outpatient Services, Physician Home Visits and Office Services, Emergency Health Care Services and Urgent Care Services for dental work and oral surgery 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 your condition. "Initial" dental work to repair injuries due to an accident means performed within twelve (12) months from the Injury, or as clinically appropriate and includes all examinations and

treatment to complete the repair. For a child requiring facial reconstruction due to a dental related Injury, there may be several years between the accidental Injury and the final repair.

Covered Services for dental services related to accidental Injury include, but may not be limited to:

- Oral examinations;
- Dental X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/maxillary reconstruction;
- Anesthesia.

The only other Dental Health Care Services that are Covered Services are Facility charges for Outpatient Services. Benefits are payable for the removal of teeth or for other dental processes only if the Covered Person's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the Covered Person.

Limitations

Covered Services are limited to $3,000 per Member per Injury. Injury as a result of chewing or biting is not considered an accidental Injury, and Health Care Services related to such injuries are not Covered Services.

6. DIABETIC EDUCATION, EQUIPMENT, AND SUPPLIES

Description

The Plan provides Benefits for diabetes self-management training if you have insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by Pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a Podiatrist; and
- Rendered by a Network Provider who is appropriately licensed, registered, or certified under state law to provide such training.

Covered Services also include all Physician or Podiatrist prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See the sections below on "Medical Supplies, "Durable Medical Equipment and Appliances," "Preventive Health Care Services," and "Physician Home Visits and Office Services."

Limitations

Covered Services for diabetes self-management training must be provided by a certified, registered or licensed Provider with expertise in Diabetes.

7. DIAGNOSTIC SERVICES

Description

The Plan provides Benefits for non-invasive Diagnostic Services, including but not limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease;
- Laboratory and pathology services;
- Advanced Imaging such as: MRI, MRA, PET, SPECT and CT imaging procedures;
- Allergy testing;
- Bone density testing; and
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies
- Ultrasound services
- Electrocardiograms
- Electromyograms, except that surface EMG's are not Covered Services
- Echocardiograms
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure
- Echographies
- Doppler Studies
- Brainstem evoked potentials (BAER)
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies
- Muscle testing
- Electrocorticograms

The Plan provides Benefits for central supply (IV tubing) or pharmacy (dye) necessary to perform Diagnostic Services covered by the Plan.

Authorization Requirements

Coverage for certain Diagnostic Services may be subject to Prior Authorization. Please review the Prior Authorization list posted on CareSource.com/marketplace for further detail. You should always check with your Provider to make sure he or she has obtained necessary Prior Authorization.

Limitations

You must ensure the laboratory you or your Provider use is a Network Provider. Please check with your Provider to ensure the laboratory he or she uses is a Network Provider. Claims from laboratories that are non-Network Providers will be considered Non-Covered Services.

8. EMERGENCY HEALTH CARE SERVICES

Description

The Plan provides Benefits for Emergency Health Care Services (Please refer to Section 3: *Important Information on Emergency, Urgent Care, and Inpatient Services*). Health Care Services which we determine to meet the definition of Emergency Health Care Services will be Covered Services, whether the care is rendered by a Network Provider or a Non-Network Provider. The Plan provides Benefits for treatment of an Emergency Medical Condition, the Emergency Medical Condition screening and the services to Stabilize an Emergency Medical Condition without Prior Authorization for conditions that reasonably appear to constitute an Emergency Medical Condition based upon your presenting symptoms and conditions. Benefits for Emergency Health Care Services include Health Care Services needed to evaluate, stabilize, or treat an Emergency Medical Condition in the emergency room.

Whenever you are admitted as an Inpatient directly from a Hospital Emergency Room, the entire visit, including Emergency Health Care Services received in the Emergency Room, will be treated as an Inpatient Stay, and the applicable Copayment and Coinsurance will apply. For Inpatient Stays following Emergency Health Care Services, Prior Authorization is not required. However, you must notify us or verify that your Physician has notified us of your admission within twenty-four (24) hours or as soon as possible within a reasonable amount of time. When we are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling us, you may avoid financial responsibility for any Inpatient Stay that is determined to be not Medically Necessary.

Limitations

Follow-up care and other care and treatment provided after you have been Stabilized is no longer considered Emergency Health Care Services. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will not be covered unless we authorize the continuation of such care and it is Medically Necessary.

9. FAMILY PLANNING SERVICES

Description

Please refer to Section 4: *Your Covered Services – Preventive Health Care Services* for additional information regarding what Family Planning Services are Covered Services.

10. HABILITATIVE SERVICES

Description

The Plan provides Benefits for Habilitative Services. Habilitative Services include, but are not limited to, Habilitative Services provided to children up to the age of twenty-one (21) who have a medical diagnosis of Autism Spectrum Disorder. Habilitative Services that the Plan deems to be Covered Services include:

- Outpatient Physical Rehabilitation Services including:
  - Speech and Language therapy and/or Occupational therapy, performed by licensed therapists, twenty (20) visits per Benefit Year of each type of therapy service; and
  - Clinical Therapeutic Intervention defined as therapies supported by empirical evidence. This includes, but is not limited to Applied Behavioral Analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan, twenty (20) hours per week. Requests for greater than twenty (20) hours per week require medical review and Prior Authorization.
- Mental/Behavioral Health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment, development and oversight of treatment plans. Refer to Section 4: *Your Covered Services, Behavioral Health Services*.
- Treatment of covered Autism Spectrum Disorders involves Medically Necessary, evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with one of the Autism Spectrum Disorders:
  - Behavioral health treatment (evidenced-based counseling and treatment programs, including Applied Behavioral Analysis that is both (1) necessary to develop maintain, or restore, to the maximum extent practicable, the functioning of an individual; and (2) are provided or supervised by a board certified Behavior Analyst or a licensed Psychologist, so long as the services performed are commensurate with the Psychologist's formal university training and supervised experience);
  - Pharmacy management (Medically Necessary services related to the effectiveness of medications);
  - Psychiatric care (evidence-based direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices);
  - Psychological care (evidence-based direct or consultative services provided by a Psychologist licensed in the state in which the Psychologist practices); and
  - Therapeutic care (evidence-based services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or Social Worker).

11. HOME HEALTH CARE SERVICES

Description

The Plan provides Benefits for services performed by a Home Health Care Agency or other Network Provider in your residence. Home Health Care Services include professional, technical, health aide services, supplies, and medical equipment. In order for you to qualify for Home Health Care Services, you must be confined to the home for medical reasons, and be physically unable to obtain needed services on an Outpatient basis. Covered Services include:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- Medical/Social Services.
- Diagnostic Services.
- Nutritional guidance.
- Home Health Care Agency aide services furnished by appropriately trained personnel employed by the Home Health Care Agency if you are receiving skilled nursing or therapy. Organizations other than Home Health Care Agencies may provide services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Agency.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the *Schedule of Benefits* for Home Health Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).
- Private Duty Nursing: The Plan provides Benefits for up to a maximum of one hundred (100) eight (8) hour private duty nursing visits per Benefit Year. A visit equals eight (8) hours or less.
- **Home infusion therapy:** The Plan provides Benefits for Home Infusion Therapy. Benefits for Home Infusion Therapy include nursing, Durable Medical Equipment and pharmaceutical services that are delivered and administered intravenously in the home. Home IV therapy includes: injections, total parenteral nutrition, enteral nutrition therapy, antibiotic therapy, pain management and chemotherapy.

Authorization Requirements

Your Provider must obtain our Prior Authorization before you receive Home Health Care Services, unless otherwise noted in this EOC. Please confirm that your Provider has obtained Prior Authorization from us before receiving such services.

Limitations

The Plan provides Benefits for up to a maximum of one hundred (100) Home Health Care Services visits per Benefit Year. Each visit by an authorized representative of a Home Health Care Agency shall be considered as one (1) Home Health Care visit, one (1) visit equals at least four (4) hours of home health aide services.

NOTE: The one hundred (100) visit limit maximum for Home Health Care Services does not include private duty nursing or home infusion therapy rendered in the home.

Non-Covered Services include but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges billed by the Home Health Care Agency.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Agency.
- Services provided by a member of your family.
- Services provided by volunteer Ambulance associations for which you are not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

12. HOSPICE SERVICES

Description

The Plan provides Benefits for Hospice services if you have a Terminal Illness. Hospice care may be provided in your home or at a Hospice Facility where medical, social and psychological services are given to help treat individuals with Terminal Illnesses. Hospice services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice Benefits, you must have a Terminal Illness and a life expectancy of six (6) months or less, as confirmed by your attending Physician. Hospice Benefits will continue if you live longer than six (6) months.

Hospice services that qualify as Covered Services include the following:

- Skilled Nursing Services (by an R.N. or L.P.N.).
- Diagnostic Services.
- Physical, speech and inhalation therapies, if part of a treatment plan.
- Medical supplies, equipment and appliances.
- Counseling services.

- Inpatient Stay at a Hospice Facility.
- Prescription Drugs given by the Hospice.
- Home health aide services.

Authorization Requirements

Coverage for certain Hospice Services may be subject to Prior Authorization. Please review the Prior Authorization list posted on CareSource.com/marketplace for further detail. You should always check with your Provider to make sure he or she has obtained necessary Prior Authorization.

Non-Covered Services include, but are not limited to:

-
- Services provided by volunteers.
- Housekeeping services.

13. INFERTILITY SERVICES

Description

The Benefit Plan covers services for the diagnosis and treatment of infertility when provided by or under the direction of a Network Provider. Covered Services include Medically Necessary treatment and procedures that diagnose or treat a medical condition that results in infertility (e.g., endometriosis, blockage of fallopian tubes, varicocele, etc.).

Limitations

Not all services connected with the treatment of infertility are Covered Services. Refer to Section 6: *What Is Not Covered.*

14. INPATIENT SERVICES

Description

The Plan provides Benefits for Inpatient Services, including:

- Charges from a Hospital or Skilled Nursing Facility (SNF) or other Provider as authorized by us for room, board and general nursing services, as follows:
  - A room with two (2) or more beds.
  - A private room. The private room allowance is the Hospital's average Semi-private Room rate unless it is Medically Necessary that you use a private room for isolation and no isolation Facilities are available.

- A room in a special care unit approved by us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

- Ancillary (related) services, as follows:
  - Charges for operating, delivery and treatment rooms and equipment.
  - Prescription Drugs.
  - Anesthesia, anesthesia supplies and services.
  - Medical and surgical dressings, supplies, casts and splints.
  - Diagnostic Services.
  - Therapy Services.

- Physician services you receive during an Inpatient Stay, as follows:
  - Physician visits that are limited to one (1) visit per day by any one Physician.
  - Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time.
  - Concurrent care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two (2) or more Physicians during one (1) Inpatient Stay when the nature or severity of your condition requires the skills of separate Physicians.
  - A consultation, which is personal bedside examination by another Physician, when requested by your Physician.
  - Surgery and the administration of general anesthesia.
  - Newborn exam. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

When you are transferred from one Hospital or Facility to another Hospital or Facility on the same day, any Copayment per admission in the *Schedule of Benefits* is waived for the second admission.

Authorization Requirements

Your Provider must obtain our Prior Authorization from us before an Inpatient Stay, unless otherwise noted in this EOC. Please confirm that your Provider has obtained Prior Authorization from us before receiving such services.

Limitations

The Plan provides Benefits for a maximum of ninety (90) days per Benefit Year for Skilled Nursing Facility stays.

The Plan provides Benefits for a maximum of sixty (60) days per Benefit Year for Inpatient Rehabilitation Facility stays.

15. MATERNITY SERVICES

Description

The Plan provides Benefits for Maternity Services. Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated Pregnancy, miscarriage, Therapeutic Abortion, and ordinary routine nursery care for a healthy newborn.

If you are pregnant when your Benefits begin, please refer to the Continuity of Care for New Covered Persons provisions in Section 2: *How the Plan Works*. These provisions describe how the Plan provides coverage for Non-Network Providers if you are in your second or third trimester of Pregnancy.

If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

Coverage for the postpartum Inpatient Stay for you and your newborn child in a Hospital will be, at a minimum, forty-eight (48) hours for a vaginal delivery and ninety-six (96) hours for a cesarean section. Coverage for a length of stay begins at the time of delivery, if delivery occurs in a Hospital, or at the time of admission in connection with childbirth if delivery occurs outside of a Hospital. Coverage for a postpartum Inpatient Stay that exceeds forty-eight (48) hours for a vaginal delivery and ninety-six (96) hours for a cesarean section may require Prior Authorization. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if you consent to such shorter stay and your attending Physician, or if a certified nurse-midwife is attending you in collaboration with a Physician, the certified nurse-midwife determines further Inpatient postpartum care is not necessary for you or your newborn child, provided that the following conditions are met:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
  - the antepartum, intrapartum, and postpartum course of the mother and infant;
  - the gestational stage, birth weight, and clinical condition of the infant;
  - the demonstrated ability of the mother to care for the infant after discharge; and
  - the availability of post discharge follow-up to verify the condition of the infant after discharge.

If your newborn is required to stay as an Inpatient past the mother's discharge date, the Inpatient Stay for the newborn past the mother's discharge date will be considered a routine nursery admission separate from Maternity Services and will be subject to a separate Inpatient Coinsurance/Copayment.

The Plan also provides Benefits for Physician or advance practice registered nurse-directed follow-up care. Covered Services for follow-up care include physical assessment of your newborn and

you, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any Medically Necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. This Benefit applies to services provided in a medical setting or through Home Health Care visits. This Benefit will apply to a Home Health Care visit only if the Network Provider who conducts the visit is knowledgeable and experienced in maternity and newborn care.

The Plan also provides Benefits for at-home post-delivery care visits by your Physician or Nurse performed no later than seventy-two (72) hours following you and your newborn child's discharge from the Hospital. Covered Services for at-home post-delivery care visits include but are not limited to:

- parent education;
- assistance and training in breast or bottle feeding; and
- performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office.

16. MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND APPLIANCES

Description

The Plan provides Benefits for the medical supplies, durable medical equipment and appliances described below. The supplies, equipment and appliances will only be Covered Services if they are Medically Necessary.

The Plan may cover the repair, adjustment and replacement of purchased equipment, supplies or appliances when approved by us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- The equipment, supply or appliance is a Covered Service;
- The continued use of the item is Medically Necessary; and
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliances may be covered if:

- The equipment, supply or appliance is worn out or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.

- Your needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
- The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

The Plan provides Benefits for:

- **Medical and surgical supplies** - Certain supplies and equipment for the management of disease that we approve will be Covered Services as Prescription Drug Services and can be found on the Prescription Drug Formulary. Benefits may be available for certain medical and surgical supplies that you do not receive as Prescription Drug Services.
    - Ostomy bags and supplies provided; however, the Plan does not provide Benefits for Health Care Services related to the fitting of such Ostomy bag and supplies.
    - Therapeutic food, formulas, supplements, and low-protein modified food products for the treatment of inborn errors of metabolism or genetic conditions if the therapeutic food, formulas, supplements, and low-protein modified food products are obtained for the therapeutic treatment of inborn errors of metabolism or genetic conditions under the direction of a Physician. Benefits available for their use are limited to conditions required by law. Prior Authorization is required.
    - Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose
    - Allergy serum extracts
    - Chem strips, Glucometer, Lancets. A limited list of Glucometer, Lancets and Diabetic Supplies are covered on the Prescription Drug Formulary.
    - Clinitest
    - Contraceptive devices including, but not limited to diaphragms, intrauterine devices (IUDs), and implants.

  We may establish reasonable quantity limits for certain supplies, equipment or appliances as described below.

Authorization Requirements

Coverage for Medical Supplies, Durable Medical Equipment and Appliances may require Prior Authorization. Always check with your Provider to make sure he or she has obtained necessary Prior Authorization.

Limitations

Reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

The following items are not Covered Services:

- Adhesive tape, Band-Aids, cotton tipped applicators
- Arch Supports
- Donut cushions
- Hot packs, ice bags
- Vitamins, except those covered under the Prescription Drug Formulary as a Preventive Service.
- Medinjectors

If you have any questions regarding whether a specific medical or surgical supply is covered, please call Member Services.

- **Durable Medical Equipment** –The Plan covers the rental (or, at our option, the purchase) of Durable Medical Equipment prescribed by a Physician or other Provider. Rental costs must not be more than the purchase price of the Durable Medical Equipment. The Plan will not pay for rental for a longer period of time than it would cost to purchase the equipment. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the Durable Medical Equipment is a rental, and medically fitting supplies are included in the rental; or the Durable Medical Equipment is owned by you; medically fitting supplies may be paid separately. Durable Medical Equipment must be purchased when it costs more to rent it than to buy it. Repair of Durable Medical Equipment may be covered as set forth herein.

  Covered Services for Durable Medical Equipment include but are not limited to:

  - Hemodialysis equipment
  - Crutches and replacement of pads and tips
  - Pressure machines
  - Infusion pump for IV fluids and medicine
  - Glucometer (select Brands are covered under the Prescription Drug Formulary)
  - Tracheotomy tube
  - Cardiac, neonatal and sleep apnea monitors
  - Augmentive communication devices are covered when we approve based on your condition
  - Wheelchairs
  - Hospital beds
  - Oxygen equipment

Limitations

The following are not Covered Services:

- Air Conditioners
- Ice bags/cold pack pump
- Raised Toilet Seats
- Rental Equipment if the Covered Person is in a Facility that is expected to provide such equipment
- Translift chairs
- Treadmill exerciser
- Tub Chair used in shower

If you have any questions regarding whether a specific Durable Medical Equipment is covered, call the Member Services number on the back of your ID Card.

- **Prosthetics –** The Plan provides Benefits for certain prosthetics. The Plan covers artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

  - Replace all or part of a missing body part and its adjoining tissues; or
  - Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services for prosthetics include, but are not limited to:

  - Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  - Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  - Breast prosthesis whether internal or external, following a mastectomy, and four (4) surgical bras per Benefit Year, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  - Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.

- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or eyeglasses prescribed following lens implantation are Covered Services. If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session. Eyeglasses (for example bifocals) including frames or contact lenses are Covered Services when they replace the function of the human lens for conditions caused by cataract surgery or aphakia. The first pair of contact lenses or eyeglasses following surgery are covered. The donor lenses inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the Injury is to one eye or if cataracts are removed from only one eye and you select eyeglasses and frames, reimbursement for both lenses and frames will be covered.
- Cochlear implant.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis)
- Wigs (the first one following cancer treatment, not to exceed one (1) per Benefit Year).

Authorization Requirements

Coverage for Cochlear implant requires Prior Authorization. Please check with your Provider to make sure he or she has obtained necessary Prior Authorization.

Limitations

The following are not Covered Services:

- Denture, replacing teeth or structures directly supporting teeth
- Dental appliances when the primary diagnosis is dental in origin. This exclusion does not apply to dental appliances for which Benefits are provided as described under Section 4 – Your Covered Services - Dental Services – Pediatric.
- Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets
- Artificial heart implants
- Penile prosthesis when the primary diagnosis is suffering from impotency resulting from disease or Injury.

If you have any questions regarding whether specific Prosthetic Equipment is covered, call the Member Services number on the back of your ID Card.

- **Orthotic Devices –** The Plan provides Benefits for certain orthotic devices. The Plan provides Benefits for the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. Orthotic devices include Medically Necessary custom fabricated braces or supports that are designed as a component of a prosthetic device. The cost of

casting, molding, fittings, and adjustments are covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Covered Services for orthotic devices may include but are not limited to:

- Cervical collars.
- Ankle foot orthosis.
- Back and special surgical corsets.
- Splints (extremity).
- Trusses and supports
- Slings.
- Wristlets
- Build-up shoe.
- Custom made shoe inserts.

Orthotic appliances may be replaced once per Benefit Year when Medically Necessary. Additional replacements may be allowed if an appliance is damaged and cannot be repaired or you are under the age of eighteen (18) and the need for the replacement is due to your rapid growth.

Limitations

The following are not Covered Services:

- Orthopedic Shoes (except therapeutic shoes for diabetics)
- Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace
- Standard elastic stockings, garter belts and other supplies not specifically made and fitted (except as specified under Medical Supplies).
- Garter belts or similar devices

17. OUTPATIENT SERVICES

Description

The Plan provides Benefits for Outpatient Services. Outpatient Services include Facility, ancillary, Facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider (including an ambulatory surgical center) as determined by the Plan. These Facilities may include a non-Hospital site providing Diagnostic Services, therapy services, surgery, or rehabilitation, or other Provider Facility as determined by us.

When Diagnostic Services or other therapy services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) are the only Outpatient Services charged, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these Health Care Services.

Authorization Requirements

Coverage for Outpatient Services may require Prior Authorization. Always check with your Provider to make sure he or she has obtained necessary Prior Authorization.

Limitations

Professional charges only include services billed by a Network Physician or other Network Provider.

18. PHYSICIAN HOME VISIT AND OFFICE SERVICES

Description

The Plan provides Benefits for care provided by a Physician, nurse practitioner, or physician assistant in his or her office or your home. This includes care provided by your PCP or a Specialist. Refer to the sections titled "Preventive Health Care Services," "Maternity Care," "Home Health Care Services" and "Behavioral Health Care Services" for services covered by the Plan. For Emergency Health Care Services, refer to the "Emergency Health Care Services" section. The Plan provides Benefits for:

Office Visits for medical care and consultations to examine, diagnose, and treat a Sickness or Injury performed in the Provider's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a Provider's office, no Copayment is required. Coinsurance is not waived.

Home Visits for medical care and consultations to examine, diagnose, and treat a Sickness or Injury performed in your home.

Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

Surgery and surgical services (including anesthesia and supplies) including normal post-operative care.

Telemedicine Health Care Services see *Section 4 - Your Covered Services: Telemedicine Health Care Services* for more information.

Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider. See *Section 4 – Your Covered Services: Therapy Services* for more information.

19. PHYSICAL MEDICINE AND REHABILITATION SERVICES

Description

The Plan provides Benefits for a structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to improve an individual's ability to function as independently as possible. This includes skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and the services of a Social Worker or Psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Covered Services for physical medicine and rehabilitation involve several types of therapy and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

The Plan provides Benefits for Day Rehabilitation program services provided through a Day Hospital for physical medicine and rehabilitation. A day rehabilitation program is for those individuals who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day Rehabilitation program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuro-psychological services. A minimum of two (2) therapy services must be provided for this program to be a Covered Service.

Limitations

Limited to a combined 60 days per Benefit Year maximum for both Inpatient and Day Rehabilitation therapy services.

Non-Covered Services for physical medicine and rehabilitation include admissions to a Hospital mainly for physical therapy and long term rehabilitation in an Inpatient setting.

20. PRESCRIPTION DRUGS

Please refer to Section 5: *Prescription Drugs* for information on your Prescription Drug coverage.

21. PREVENTIVE HEALTH CARE SERVICES

The Plan provides Benefits for Preventive Health Care Services as part of your Essential Health Benefits, as determined by federal and state law. The Plan will cover Preventive Health Care Services at no cost to you if provided by a Network Provider.

Preventive Health Care Services in this section must meet requirements as determined by federal and state law. Preventive Health Care Services fall under four (4) broad categories. The categories are:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
  - Breast cancer mammography screening;

  - Cervical cancer;
  - Colorectal cancer (colonoscopy);
  - High Blood Pressure;
  - Type 2 Diabetes Mellitus;
  - Cholesterol; and
  - Child and Adult Obesity.

- Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive Health Care Services for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional Preventive Health Care Services for women provided for in the guidelines supported by the Health Resources and Services Administration, including:
  - Food and Drug Administration (FDA) approved women's contraceptives, sterilization procedures, and counseling.
  - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one (1) breast pump per pregnancy.
  - Gestational diabetes Screening.

Please refer to Section 5: *Prescription Drugs* for information on your Prescription Drug coverage for Drugs covered as Preventive Services.

You may call Member Services for additional information about these services or review the federal government's web sites:

- http://www.uspreventiveservicestaskforce.org/
- http://www.healthcare.gov/what-are-my-preventive-care-benefits/
- http://www.ahrq.gov/clinic/uspstfix.html
- http://www.cdc.gov/vaccines/acip/index.html

Covered Services also include the following services required by state and federal law:

- Routine cytologic screening for the presence of cervical cancer and chlamydia screening (including pap test).
- Routine hearing screenings. See *Section 4 – Your Covered Services: Routine Hearing Services, Hearing Aids, and Related Services*, for more information.
- Sports physicals for children who are in elementary school through high school.
- Voluntary family planning services.

- Preventive Benefits for screening mammograms are as follows: (a) if a woman is at least forty (40) years of age but under fifty (50) years of age, one screening mammogram every two (2) years; provided, however, that the Plan will cover one (1) screening mammogram per Benefit Year if a Physician has determined that the woman has risk factors to breast cancer; and (b) if a woman is at least fifty (50) years of age or older, one (1) screening mammogram every year.
- In addition to the above preventive screening mammogram Benefit, the state of Ohio requires coverage for screening of mammograms if a woman is at least thirty-five (35) years of age but under forty (40) years of age. However, women who are at least thirty-five (35) years of age but under forty (40) years of age and are Covered Persons receiving a screening mammogram under this paragraph may be responsible for any applicable Copayment, Coinsurance, and Deductible amounts. The total Benefit for a screening mammogram shall not exceed one hundred thirty percent (130%) of the Medicare reimbursement rate in the State of Ohio for screening mammograms. If there is more than one Medicare reimbursement rate in the State of Ohio for screening mammograms or a component of a screening mammogram, the reimbursement limit shall be one hundred thirty percent (130%) of the lowest Medicare reimbursement rate in the State of Ohio. You may not be billed for costs in excess of any applicable Copayment, Coinsurance or Deductible.
- Breast Cancer Genetic Test Counseling (BRCA1 and BRCA2) which includes mutation testing for individuals who have family members with breast, ovarian, fallopian tube, or peritoneal cancer.
- Tobacco cessation services: (1) screening for tobacco use; and (2) two cessation attempts per Benefit Year, consisting of four (4) sessions of telephone, individual and group cessation counseling lasting at least ten (10) minutes each per quit attempt and all medications approved by the United States Food and Drug Administration as safe and effective for smoking cessation, for ninety (90) days per quit attempt, when prescribed by your Provider.

We will give you at least sixty (60) days written notice before the effective date of any material modification to the list of covered Preventive Health Care Services in accordance with federal law.

22. RECONSTRUCTIVE SERVICES

Description

The Plan provides Benefits for certain reconstructive services required to correct a deformity caused by disease, trauma, Congenital Anomalies, or previous therapeutic process. Covered Services include the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.

- Breast reconstruction resulting from a mastectomy. See Section 12 for the Women's Health and Cancer Rights Act Notice;
- Hemangiomas, and port wine stains of the head and neck areas for children ages eighteen (18) years or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip; and
- Cleft palate.

Authorization Requirements

Your Provider must obtain Prior Authorization from us for reconstructive services. Please confirm that your Provider has obtained Prior Authorization from us before receiving such services.

23. ROUTINE HEARING SERVICES, AND RELATED SERVICES

Important Information

The Benefits available to you under this Section are administered by TruHearing™ through the TruHearing™ Choice Program. The management and other services that TruHearing provides include, among others, maintaining and managing the Network Providers who will provide Covered Services to you under this Section. You must use a TruHearing Network Provider in order to receive Benefits under this Section. If you do not use a TruHearing Network Provider to receive Health Care Services under this Section, then you will be responsible for all costs and such Health Care Services will be considered Non-Covered Services. Please call 1-866-202-2674 for help locating a TruHearing Network Provider and for additional information and details.

Description

The plan provides benefits for the following routine hearing services:

1. Routine Hearing Screening: Covered in Full every benefit year includes a simple pass or fail test to determine if you have normal hearing or not. Usually consists of a series of beeps or tones at the limit of normal range.
2. Routine Hearing Exam: Covered in Full every benefit year including a comprehensive examination performed by a licensed audiologist or hearing instrument specialist that generally includes a review of your full case history, several types of hearing tests, counseling to understand results, and recommendations on appropriate treatment.

Additional services:

TruHearing™ also provides access to purchase hearing aids at discounted prices not offered to the general public through the TruHearing™ Choice Program. The TruHearing™ Choice Program includes numerous models of hearing aids from major manufacturers ranging from basic to premium hearing aid technology and reflecting varying levels of discount off the retail price. The TruHearing™ Choice Program is a service you have access to as a Covered Person, but shall not be considered a Benefit under the Plan.

Covered Persons selecting hearing aids at discounted prices under the TruHearing™ Choice Program will be responsible for 100% of the hearing aid costs.

Limitations

- Routine Hearing Screening is limited to one (1) each Benefit Year
- Routine Hearing Exam is limited to one (1) each Benefit Year
- Covered Services provided within this section must be provided by a TruHearing™ Network Provider.
- Non-routine and medical based hearing exams are not covered within this category of this Evidence of Coverage.

24. STERILIZATION

Description

The Plan provides Benefits for male surgical sterilization procedures and related services received in a Physician's office or on an Outpatient basis at a Hospital or Alternate Facility. Benefits for sterilization procedures for women will be covered under Preventive Health Care Services. Please see that Section for more information.

Benefits under this category include the Facility charge, the charge for required Hospital-based professional services, supplies and equipment and for the surgeon's fees.

25. SURGICAL SERVICES

Description

The Plan provides Benefits for surgical services when provided as part of Physician Home Visits and Office Services, Inpatient Stays, or Outpatient Services. Surgical Services will only be Covered Services when provided in an appropriate setting, as determined by us. Such Benefits include but are not limited to:

- Performance of accepted operative and other invasive procedures, including but not limited to:
    - Operative and cutting procedures;

  - Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy; and
  - Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary (including when provided by a registered nurse first assistant, certified surgical assistant, or physician assistant);
- Usual and related pre-operative and post-operative care; or
- Other procedures as approved by us.

We may combine the Benefits when more than one (1) surgery is performed during the same operative session.

Authorization Requirements

Your Provider must obtain Prior Authorization from us for Surgical Services. Please confirm that your Provider has obtained Prior Authorization from us before receiving such services.

26. TELEMEDICINE HEALTH CARE SERVICES

Covered Services include a medical or health consultation for purposes of diagnosis and/or treatment using your Smartphone, tablet, computer or other computing device. Telemedicine Health Care Services may be received from your PCP or other network Provider, and are available 24 hours per day, 365 days per year from MYidealDOCTOR™.

You should consider Telemedicine Health Care Services if:

- You are considering visiting an emergency or urgent care provider for non-emergency health care; or
- You or your dependent(s) need care immediately and your physician is not available.

Schedule an appointment with MYidealDOCTOR™ by calling 1-855-879-4332 or visit www.myidealdoctor.com.

Any Annual Deductible, Coinsurance, Copayment, or Annual Out-of-Pocket Maximum for Telemedicine Health Care Services will not be less favorable than the Annual Deductible, Coinsurance, Copayment, or Annual Out-of-Pocket Maximum that applies to Physician Home Visit and Office Services.

Limitations

Covered Services do not include normal communication with your PCP or other Network provider, including, but not limited to the following:

- Reporting normal lab or other test results;

- Office appointment requests;
- Billing, insurance coverage or payment questions;
- Requests for referrals to doctors outside the online care panel;
- Benefit precertification; and
- Physician to Physician consultation.

27. TEMPOROMANDIBULAR OR CRANIOMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR JAW DISORDER

Description

The Plan provides Benefits for Temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and Craniomandibular (head and neck muscle) disorders if such services are provided in accordance with our guidelines.

Authorization Requirements

Coverage for Benefits for Temporomandibular and Craniomandibular disorders require Prior Authorization. Always check with your Provider to make sure he or she has obtained necessary Prior Authorization.

28. THERAPY SERVICES

Description

The Plan provides Benefits for certain therapy services if given as part of Physician Home Visits and Office Services, Inpatient Stays, Outpatient Services, or Home Health Care Services when a Network Provider expects that the therapy services will result in a practical improvement in the level of your functioning within a reasonable period of time.

Physical Medicine Therapy Services

The Plan provides Benefits for physical medicine therapy services when a Network Provider expects that the physical medicine therapy services will result in a practical improvement in the level of your functioning within a reasonable period of time.

The Plan will provide Benefits for physical therapy including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. In order to be considered Covered Services, physical therapy services must be provided to relieve your pain, restore your function, and to prevent disability following your Sickness, Injury, or loss of a body part.

Limitation: Twenty (20) visits per Benefit Year when rendered as Physician Home Visits and Office Services or Outpatient Services. When rendered in the home, Home Health Care Services limits apply.

NOTE: Covered Persons may receive twenty (20) physical therapy visits per Benefit Year for rehabilitation purposes in accordance with Section 4: Your Covered Services, Physical Medicine and Rehabilitation Services and may receive twenty (20) physical therapy visits per Benefit Year for Habilitative purposes in accordance with Section 4: Your Covered Services, Habilitative Services.

The Plan does not provide Benefits for physical therapy services that are for maintenance therapy; that delay or minimize muscular deterioration in individuals suffering from a chronic disease or Sickness; that are repetitive exercises to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable individuals); that are range of motion and passive exercises not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; that are general exercise programs; that are diathermy, ultrasound and heat treatments for pulmonary conditions; that are diapulse; or for work hardening.

Occupational Therapy Services

If you are physically disabled, the Plan will provide Benefits for occupational therapy by means of constructive activities designed and adapted to promote the restoration of your ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by your particular occupational role.

Limitation: Twenty (20) visits per Benefit Year when rendered as Physician Home Visits and Office Services or Outpatient Services. When rendered in the home, Home Health Care Services limits apply.

NOTE: Covered Persons may receive twenty (20) occupational therapy visits per Benefit Year for rehabilitation purposes in accordance with Section 4: *Your Covered Services, Physical Medicine and Rehabilitation Services* and may receive twenty (20) occupational therapy visits per Benefit Year for Habilitative purposes in accordance with Section 4: *Your Covered Services, Habilitative Services.*

The Plan does not provide Benefits for Qccupational Therapy, including, but not limited to those that are diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts); supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as you resume normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

Speech Therapy

The Plan will provide Benefits for speech therapy for a correction of a speech impairment. The Plan provides Benefits for up to twenty (20) visits per Benefit Year when rendered as Physician Home Visits and Office Services or Outpatient Services. When rendered in the home, Home Health Care Services limits apply.

NOTE: Covered Persons may receive twenty (20) speech therapy visits per Benefit Year for rehabilitation purposes in accordance with Section 4: *Your Covered Services, Physical Medicine and Rehabilitation Services* and may receive twenty (20) speech therapy visits per Benefit Year for Habilitative purposes in accordance with Section 4: *Your Covered Services, Habilitative Services.*

Manipulation Therapy

The Plan will provide Benefits for twelve (12) manipulation therapy that includes osteopathic/chiropractic manipulation therapy used for treating problems associated with bones, joints and the back. The two (2) therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations, whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit, will be counted toward any maximum for manipulation therapy services as specified in your this EOC or your *Schedule of Benefits*. The Plan does not provide Benefits for manipulation therapy services provided in the home as part of Home Health Care Services.

Other Therapy Services

The Plan will provide Benefits for therapy services for:

- Cardiac rehabilitation to restore your functional status after a cardiac event. Cardiac rehabilitation services includes a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered. Thirty-six (36) visits per Benefit Year when rendered as Physician Home Visits and Office Services or Outpatient Services. When rendered in the home, Home Health Care Services limits apply.
- Pulmonary rehabilitation to restore an individual's functional status after a Sickness or Injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Twenty (20) visits per Benefit Year when rendered as Physician Home Visits and Office Services or Outpatient Services. When rendered in the home, health Care Services limits apply. When rendered as part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.
- Chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- Dialysis treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
- Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes. Radiation therapy includes treatment (teletherapy, brachytherapy and intraoperative

radiation, photon or high energy particle sources); materials and supplies used in therapy; and treatment planning.

- Inhalation Therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics of inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- Post-Cochlear Implant Aural Therapy: Thirty (30) visits per Benefit Year.
- Cognitive Rehabilitation Therapy: Twenty (20) visits per Benefit Year.

Authorization Requirements

Coverage for Benefits for Therapy Services may require Prior Authorization. Always check with your Provider to make sure he or she has obtained necessary Prior Authorization.

29. TRANSPLANT: HUMAN ORGAN AND TISSUE TRANSPLANT (BONE MARROW/STEM CELL) SERVICES

Description

Covered Transplant Procedure

The Plan provides Benefits for human organ and stem cell/bone marrow transplants and transfusions when ordered by a Provider and that we determine are Medically Necessary. Such Benefits include the necessary and related acquisition procedures, harvest and storage, and preparatory myeloablative therapy if these related services are Medically Necessary.

Covered Services for human organ and stem cell/bone marrow transplants and transfusions are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the Health Care Service is performed.

Examples of transplants for which benefits are available include bone morrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel, cornea and treatment of breast cancer by high-dose chemotherapy with autologous bone marrow or stem cell transplant. Donor costs that are directly related to organ removal are Covered Services for which Benefits are payable under the Plan.

The Transplant Benefits outlined below do not apply to any Covered Services related to a Covered Transplant Procedure that are received prior to or after the Transplant Benefit Year. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and storage of bone marrow/stem cells is included in the Covered Transplant Procedure Benefit regardless of the date of service.

Live Donor Health Care Services

The Plan provides Benefits for Medically Necessary Health Care Services for the procurement of an organ from a live donor, including complications from the donor procedure for up to six (6) weeks from the date of the procurement.

NOTE: Live donor Benefits are limited to Benefits not available to the donor from any other source.

Transplant Benefit Year

The Benefit period for a covered transplant procedure begins one (1) day prior to the covered transplant procedure and continues for the applicable case rate/global time period, or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Network Transplant Provider Facility. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact a Case Manager for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility.

Transportation and Lodging

The Plan will provide certain Benefits associated with your reasonable and necessary travel expenses as determined by us if you obtain our Prior Authorization and if you are required to travel more than seventy-five (75) miles from your residence to reach the Facility where your Transplant Procedure will be performed. Your Benefit includes assistance with your travel expenses, including transportation to and from the Facility and lodging for you, as the patient, and one (1) companion. If you are receiving treatment as a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two (2) companions. You must submit itemized receipts for transportation and lodging expenses in a form satisfactory to us when Claims are filed.

Authorization Requirements

Your Provider must call us so that we can provide Prior Authorization for a Transplant Procedure. Your Provider should call the Utilization Management Department and ask for the Transplant Coordinator. Your Provider must do this before you have an evaluation and/or work-up for a transplant. We will assist your Provider and you by explaining your Benefits, including details regarding the services to which the Benefit applies, and any clinical coverage guidelines, medical policies, Network requirements, or Exclusions. If we issue a Prior Authorization for a transplant procedure, your Provider must call us prior to the transplant so that we may determine whether the transplant is performed in an Inpatient or Outpatient setting.

Please note that there are instances where your Provider may request approval for Human Leukocyte Antigen Testing (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine Diagnostic Services. We will review whether the harvest and storage request is Medically Necessary. However, such an approval for HLA testing, donor search and/or a harvest and storage is not an

approval for the subsequent requested transplant. We must make a separate determination as to whether the transplant procedure is Medically Necessary.

Limitations

The Plan provides reimbursement for transportation and lodging expenses described above up to a maximum of Ten Thousand Dollars ($10,000). The Plan provides reimbursement of up to Thirty Thousand Dollars ($30,000) for expenses related to finding a donor who is not related to you and who will be a donor for a bone marrow/stem cell covered transplant procedures. You must obtain our authorization prior to being reimbursed for these expenses. If you do not obtain authorization, you must pay for these expenses.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care;
- Mileage for travel while within the Facility's city;
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us;
- Frequent Flyer miles;
- Coupons, Vouchers, or Travel tickets;
- Prepayments or deposits;
- Services for a condition that is not directly related to, or a direct result of, the transplant;
- Telephone calls;
- Laundry;
- Postage;
- Entertainment;
- Interim visits to a medical care Facility while waiting for the actual Transplant Procedure;
- Travel expenses for donor companion/caregiver; and
- Return visits for the donor for a treatment of a condition found during the evaluation.

30. URGENT CARE SERVICES

Description

The Plan provides Benefits for Covered Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician Home Visits and Office Services* earlier in this section.

Benefits are also available for Urgent Care Services received at a Non-Network Urgent Care Center.Benefits provided under this section are payable at the Network level and are limited to the Maximum Allowable Amount. Your payment is subject to any Coinsurance, Copayment, or

Deductible. You may be responsible for any amount in excess of the Maximum Allowable Amount.

31. VISION SERVICES – PEDIATRIC

Description

The Plan provides pediatric vision Benefits for children to the end of the month in which a child turns nineteen (19) years of age.

Important Information

The Benefits available to you under this Section are administered by EyeMed™. The management and other services that EyeMed™ provides include, among others, maintaining and managing the Network Providers who will provided Covered Services to you under this Section. You must use an EyeMed™ Network Provider in order to receive Benefits under this Section. If you do not use an EyeMed™ Network Provider to receive Health Care Services under this Section, then you will be responsible for all costs, and such Health Care Services will be considered Non-Covered Services. Please call 1-833-337-3129 for help locating an EyeMed™ Network Provider and for additional information and details.

IMPORTANT: IF YOU OPT TO RECEIVE VISION CARE SERVICES OR VISION MATERIALS THAT ARE NOT COVERED BENEFITS UNDER THIS PLAN, A PARTICIPATING NETWORK PROVIDER MAY CHARGE YOU HIS OR HER NORMAL FEE FOR SUCH SERVICES OR MATERIALS. PRIOR TO PROVIDING YOU WITH VISION CARE SERVICES OR VISION CARE MATERIALS THAT ARE NOT COVERED BENEFITS, THE VISION CARE PROVIDER WILL PROVIDE YOU WITH AN ESTIMATED COST FOR EACH SERVICE OR MATERIAL UPON REQUEST.

The definitions below are specific to the Plan's coverage for pediatric vision services:

Examination means the comprehensive eye examination of an individual's complete visual system. An Eye Examination includes: case history, general patient observation, clinical and diagnostic testing and evaluation. Pupillary dilation is required for members with diabetes. The eye exam also includes refraction, color vision testing, Stereopsis testing and case presentation.

All Benefits are subject to the definitions, limitations and exclusions in this EOC and are payable only when they are deemed Medically Necessary for the prevention, diagnosis, care, or treatment of a Sickness or Injury and meet generally accepted vision protocols.

Covered Services

The Plan provides Benefits for the following pediatric vision services:

- **Examination Options:** Various types of examinations are available.
    - **Comprehensive Eye Exam with Dilation as Necessary:** Limited to one per benefit year. Includes dilation, if professionally indicated.

- **Standard Contact Lens Fit & Follow-Up**: Cost share applies, limited to one per Benefit Year.
- **Premium Contact Lens Fit & Follow-Up**: You are responsible for cost of exam less 10% discount. Limited to one per Benefit Year.

- **Eyewear: You may choose prescription glasses or contacts.**
  - **Frame and Frame Fitting:** Includes provider designated frames. Limited to once per Benefit Year.
  - **Lenses:** Limited to one pair of lenses per Benefit Year. The Plan also provides Benefits for one replacement pair every Benefit Year if it is Medically Necessary, and subject to limitations and exclusions outlined in this EOC.
    - Lens Options: see below for cost shares. If your plan is a HSA Eligible Plan, you will need to satisfy your Annual Deductible before the below cost shares will apply:
      - Standard plastic or glass - $0 Copay
      - Single vision, conventional bifocal, conventional trifocal, lenticular: $0 Copay
      - Progressive Lens
        - Standard - $0 Copay
        - Premium tier 1 - $20 Copay
        - Premium tier 2 - $30 Copay
        - Premium tier 3 - $45 Copay
        - Premium tier 4 - $0 Copay, 80% of charge less $120 allowance
      - UV treatment - $0 Copay
      - Tint (gradient, fashion or solid) - $0 Copay
      - Glass-grey #3 prescription sunglass lenses – $0 Copay
      - Standard plastic scratch coating - $0 Copay
      - Standard polycarbonate – $0 Copay
      - Oversized - $0 Copay
      - Photocromatic / transitions plastic - $0 Copay
      - Anti-reflective coating
        - Standard - $45 Copay
        - Premium tier 1 - $57 Copay
        - Premium tier 2 - $68 Copay
        - Premium tier 3 – 80% of Charge
      - Blended segment lenses - $0 Copay
      - Intermediate vision lenses - $0 Copay
      - Polarized – 20% off retail price
      - Hi-Index lenses – 20% off retail price

  - **Contact Lenses:** Once every Benefit Year – in lieu of eyeglasses.

    This includes the contact lenses and associated services, including fit and unlimited follow-ups.

Medically Necessary contact lenses are dispensed in lieu of other eyewear.

- **Low Vision:** Low vision is a significant loss of vision but not total blindness.
  - **Supplemental Testing:** Diagnostic evaluation beyond a comprehensive eye examination including, but not limited to, an ocular function assessment, measurements, visual field evaluations. Limited to one per Benefit Year.
  - **Low Vision Aids:** Includes, but is not limited to spectacle-mounted magnifiers, hand-held or spectacle-mounted telescopes, hand-held and stand magnifiers, and video magnification. Limited to one per Benefit Year.

- **Retinal Imaging Benefit:** Cost share applies. Limited to one per Benefit Year.

Additional services:

The following are services you have access to as a Covered Person, but shall not be considered a Benefit under the Plan:

1. Laser Vision Correction (Lasik or PRK from U.S. Laser Network): The Plan will not provide Benefits for laser vision correction services. However, Members may receive 15% off retail price or 5% off promotional price of the cost of laser vision correction services.
2. Additional Pairs Benefit: The Plan will only provide Benefits for one pair of glasses or contact lenses. You may purchase additional eyewear at your own cost, and you may receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses upon exhaustion of the Benefits above.
3. Lens Add-Ons: Members receive a 20% discount off Retail Price for lens options not listed above.

Exclusions:

We do not cover the following:

- Services provided by providers not within the EyeMed™ Insight Network of Providers;
- Any vision service, treatment or materials not specifically listed as a Covered Service;
- Services and materials that are Experimental or Investigational;
- Services or materials which are rendered prior to your effective date;
- Services and materials incurred after the termination date of your coverage unless otherwise indicated;
- Services and materials not meeting accepted standards of optometric practice;
- Services and materials resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;

- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Office infection control charges;
- Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
- State or territorial taxes on vision materials and services performed;
- Medical treatment of eye disease or Sickness or Injury;
- Visual therapy;
- Special lens designs or coatings other than those listed as Covered Services;
- Replacement of lost/stolen eyewear;
- Non-prescription (Plano) lenses;
- Two pairs of eyeglasses in lieu of bifocals;
- Services not performed by licensed personnel;
- Prosthetic devices and services;
- Insurance of contact lenses;
- Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption.

SECTION 5 – PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and mail order service for obtaining Prescription Drugs;
- Any Benefit limitations and Exclusions that exist for Prescription Drugs; and
- Definitions of terms used throughout this section related to the Prescription Drug Plan

How Prescription Drug Coverage Works

This section provides an overview of the Plan's Prescription Drug coverage. See your *Schedule of Benefits* for Copayment, Coinsurance, and Deductible amounts that apply when you have a prescription filled at a Network Pharmacy. If you have any questions about the Plan's Prescription Drug coverage, you may call the Pharmacy phone number listed on your ID Card.

You are responsible for paying any amounts due to the Pharmacy at the time you receive your Prescription Drugs. You must notify CareSource to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket.

Pharmacy Innovation Partner (PIP)

CareSource has partnered with our Pharmacy Innovation Partner to provide members holistic care and coordination of pharmacy, medical and behavioral Benefits. The Pharmacy Benefits available to you under this EOC are administered by our PIP. The management and other services the PIP provides include, among others, making recommendations and updating the covered Marketplace Prescription Drug List, managing a network of retail pharmacies, and operating a Mail Service Pharmacy and a Specialty Drug Pharmacy Network. The PIP, in consultation with us, also provides services to promote and enforce the appropriate use of Pharmacy Benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/Pregnancy concerns; safety or adherence.

Our covered Prescription Drug List is available online. The CareSource website includes a formulary lookup tool from which you can search for a particular drug, or you may also call Member Services. The covered Prescription Drug List is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug List is not a guarantee of coverage. Your Provider or Network Pharmacist may check with us to verify covered Prescription Drugs, any quantity and/or age limits, or applicable Brand-name Drugs or Generic Drugs recognized under the Plan.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary in order to be Covered Services. Prescription Drugs will be covered for FDA approved indications. Prescription drugs will also be covered for off-label uses provided that the drug has been recognized as safe and effective for the treatment of your condition in standard medical literature. Both State and

Federal laws define standard medical literature, but usually consist of multiple articles from peer-reviewed medical journals, clinical practice guidelines as recognized by nationally recognized medical organizations, national panels or consortiums such as the National Institutes of Health or Centers for Disease Control and Prevention, and more.

For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before we can determine Medical Necessity or if the request is for a covered service or indication. We may establish limits for specific Prescription Drugs. Covered Services will be limited based on Medical Necessity, coverage limits established by us, or utilization guidelines. Coverage limits could include dose limits, quantity limits, duration limits, age or gender limits, and more. When a limit is exceeded, Prior Authorization may apply.

Prior Authorization may be required for certain Prescription Drugs. Prior Authorization helps promote appropriate and safe utilization and enforcement of guidelines for Prescription Drug Benefit coverage. From time to time, CareSource may change the Prescription Drugs requiring notification. To determine if a Prescription Drug requires Prior Authorization, visit our website or call the toll-free number on your ID Card. Also, at the time you fill a prescription, the Network pharmacist is informed of the Prior Authorization requirement through the Pharmacy's computer system.

CareSource uses pre-approved criteria, developed by our Pharmacy and Therapeutics Committee, which is reviewed and adopted by us. Prior Authorization and/or Limits to coverage are also subject to state or federal laws (such as those applying to the dispensing of controlled substances as only one example). We may contact your Provider if additional information is required for Prior Authorization decisions. We communicate the results of the decision to both you and your Provider.

If Prior Authorization is denied, you have the right to appeal through the appeals process outlined in the Complaint and Appeals Procedures section of this EOC.

Prior Authorizations for Covered Persons with Chronic Conditions

For Prior Authorizations related to a Covered Person’s Chronic Condition, we will honor the Prior Authorization for an approved Prescription Drug for twelve (12) months or until the last day of the Covered Person’s eligibility under the Plan, whichever is less.

NOTE: The duration of all other Prior Authorization approvals will be governed by the Plan and this Evidence of Coverage. The twelve (12) month approval provided by us will no longer be valid and will automatically terminate if there are changes to federal or state laws or federal regulatory guidance or compliance information prescribing that the Prescription Drug in question is no longer approved or safe for the intended purpose.

We may require a Covered Person’s Provider to submit information to us indicating that a Covered Person’s Chronic Condition has not changed. The frequency of the submission of requested information by the Plan will be consistent with medical or scientific evidence as required by law, but will not be required more frequently than on a quarterly basis.

NOTE: If we request information from a Covered Person's Provider and the Provider does not respond to us within five (5) days from the date the request was received by the Provider, we may terminate the twelve (12) month approval.

We will not authorize a twelve (12) month approval for the following:

1. Prescription Drugs that are prescribed for a non-maintenance condition;

2. Prescription Drugs that have a typical treatment of less than one (1) year;

3. Prescription Drugs that require an initial trial period to determine effectiveness and tolerability, beyond which a one (1) year or greater Prior Authorization period will be given;

4. Prescription Drugs where the medical or scientific evidence, as defined in Ohio Revised Code 3922.01, does not support a twelve (12) month prior approval;

5. Prescription Drugs that are a Schedule I or II controlled substance or any opioid analgesic or benzodiazepine, as defined in Ohio Revised Code 3719.01; or

6. Prescription Drugs that are not prescribed by a Network Provider as part of a care management program.

NOTE: If we have provided a twelve (12) month approval for a Prescription Drug and the United States Food and Drug Administration subsequently releases an approved comparable brand or generic Prescription Drug that is listed as therapeutically equivalent in United States Food and Drug Administration's publication titled "Approved Drug Products with Therapeutic Equivalence Evaluations," then we may require a substitution and require the therapeutically equivalent Prescription Drug be used for the remainder of the twelve (12) month approval.

Benefit Levels

Benefits are available for Outpatient Prescription Drugs that are considered Covered Services.

Tiers of Covered Drugs and Your Cost Share

Your Copayment or Coinsurance amount may vary based on whether the covered Prescription Drug, including covered Specialty Drugs, has been classified by us as a Tier 0, 1, 2, 3, 4, or 5 drug. Tiers are based upon clinical information, the cost of the drug compared to other similar drugs used to treat the same or similar condition; the availability of over-the-counter alternatives; and certain clinical economic factors. The different tiers are below.

- Tier 0: Prescription Drugs include preventive medications. These medications are available without a Copayment or Coinsurance.
- Tier 1: Low cost Drugs.

- Tier 2: Prescription Drugs that have a higher Coinsurance or Copayment than those in Tier 1. This tier will contain preferred medications that may be single, multi-source Brand-name, or Generic Drugs.
- Tier 3: Prescription Drugs that have a higher Coinsurance or Copayment than those in Tier 2. This tier will contain non-preferred medications that may be single, multi-source Brand-name, or Generic Drugs.
- Tier 4: Prescription Drugs that have a higher Coinsurance or Copayment than those in Tier 3. This tier will contain medications that are generally classified as specialty preferred medications. This may also include specialty preferred Generic Drugs.
- Tier 5: Prescription Drugs that have a higher Coinsurance or Copayment than those in Tier 4. This tier will contain medications that are generally classified as specialty non-preferred medications. This may also include specialty non-preferred Generic Drugs.

For Prescription Drugs at a retail Network Pharmacy, you must pay for the lower of:

- The Copayment, Coinsurance, and Deductible amounts that are applicable;
- The Network Pharmacy's usual and customary charge for the Prescription Drug; or
- The Prescription Drug Cost that CareSource agreed to pay the Network Pharmacy.

For Prescription Drugs from a mail order Network Pharmacy, you are responsible for paying the lower of:

- The Copayment, Coinsurance, and Deductible amounts that are applicable; or
- The Prescription Drug Cost for that particular Prescription Drug.

Copay Cards, also called rebate cards or discount cards, may be available to you from some drug manufacturers who offer very high cost Brand drugs. These programs may apply after your Prescription Drug claim has been paid by CareSource. Money paid to reduce your cost share by these programs will not be permitted to apply toward your Deductible or Annual Out-of–Pocket Maximum under your Plan. Money received through these copay cards may jeopardize High Deductible benefit plans and their tax savings with the Internal Revenue Service.

Assigning Prescription Drugs to Tiers

Prescription Drugs are placed into tiers based on an evaluation of a number of factors including, but not limited to, clinical and economic factors.

Clinical factors may include:

- Evaluations of the place in therapy;
- Relative safety and efficacy; and

- Whether supply limits or notification requirements should apply.

Economic factors may include:

- The acquisition cost of the Prescription Drug; and
- Available rebates and assessments on the cost effectiveness of the Prescription Drug

When evaluating a Prescription Drug for tier placement, clinical and economic factors regarding Covered Persons as a general population are considered. Whether a particular Prescription Drug is appropriate for an individual Covered Person is a decision that is made by the Covered Person and the prescribing Physician. Tier placement of Prescription Drugs is routinely assessed and may change from time to time.

How to Obtain Prescription Drug Benefits

We will only cover Prescription Drugs filled by a Network Pharmacy. The Plan does not provide Benefits for Prescription Drugs filled by a Pharmacy that is a Non-Network Provider.

Network Pharmacy

When Prescription Drugs are dispensed at a Network Pharmacy, you must present your written prescription order from your Provider and your ID Card. The Network Pharmacy will file your Claim for you, and you will be required to pay applicable Deductible, Copayment or Coinsurance amounts at the Network Pharmacy.

If you do not present your ID Card, you will have to pay the full retail price of the Prescription Drug. If you do pay the full charge, ask your Pharmacist for an itemized receipt. You will need to complete a form and return it to our PIP for reimbursement. When you submit a Claim on this basis, you may pay more because you did not notify the PIP before the Prescription Drug was dispensed. The amount you are refunded will be based on the Prescription Drug Cost (less the required Copayment and/or Coinsurance and any Deductible that applies).

Benefits may not be available for the Prescription Drug after the PIP reviews the documentation provided and determines that the Prescription Drug is not a Covered Service, was dispensed without Prior Authorization received, exceeded plan limits without authorization, or it is used as an Experimental or Investigational or Unproven Service.

Specialty Drugs

You or your Physician must order your specialty drugs directly from your PIP's specialty Pharmacy by calling Member Services. There are certain medications that are more complex for diseases that require special attention and need to be handled differently than medications you pick up at your local Pharmacy. These medications are called specialty medications, and most of these medications require a Prior Authorization from your Provider. Many of these medications need to be given to you by a Physician or nurse, and your Provider’s office will help you get that done. If the Prior Authorization is approved, we will work with your Provider’s office and the specialty Pharmacy.

Specialty Drugs are limited to up to a maximum of 30 days' supply from the Specialty Pharmacy where clinically appropriate or less.

Non-Network Pharmacy

You are responsible for full payment of the entire amount charged by a Pharmacy that is a Non-Network Provider.

The Mail Service Program

Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from your Physician to the Mail Service or have your Physician fax the prescription to the Mail Service. Your Physician may also phone in the prescription to the Mail Service. You will need to submit the applicable Coinsurance and/or Copayment amounts to the Mail Service when you request a prescription or refill. Not all covered Prescription Drugs are available through the Mail Service Program.

You are not required to use the Mail Service Program.

Special Programs

From time to time we may start programs to encourage you to use more cost-effective or clinically-effective Prescription Drugs including, Generic Drugs, mail service drugs, and over-the-counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain drugs or preferred products for a limited period of time.

Therapeutic Substitution of Drugs Program

Therapeutic Substitution of Drugs is a program designed to increase Generic Drug use, which lowers your medication costs and maintains safety and efficacy.

This program informs you and your Provider about possible alternatives to certain Prescription Drugs. We may contact you and your prescribing Provider to make you aware of substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only you and your Provider can determine whether the therapeutic substitute is appropriate for you. The therapeutic drug substitutes list is subject to periodic review and amendment.

Step Therapy

Step therapy means that you may need to use one type of medication before another. The PIP monitors some Prescription Drugs to control use, to ensure that appropriate prescribing guidelines are followed, and to help you access high quality, yet cost effective, Prescription Drugs. If your Provider decides that a step therapy medication is needed, your Provider may request an exemption. We will review and respond to your Provider's request for an exemption within forty-eight (48) hours for urgent requests, and within ten (10) calendar days for all other requests.

NOTE: If we deny your Provider's request for an exemption, your Provider may appeal the decision. The appeal will be between the Provider and a clinical peer. We will respond to your Provider's appeal within forty-eight (48) hours for expedited appeals, and within ten (10) calendar days for all other appeals.

NOTE: If we deny the appeal, you or your representative may request an External Review.

Designated Pharmacy

If you require certain Prescription Drugs, CareSource may direct you to a Designated Pharmacy that offers those Prescription Drugs.

Opioid Analgesics Prescribed for Chronic Pain

Covered Persons prescribed Opioid Analgesics for Chronic Pain must obtain our Prior Authorization prior to receiving Opioid Analgesics for Chronic Pain, except under the following circumstances:

1. Opioid Analgesics prescribed to a Covered Person who is a Hospice Patient in a Hospice Care Program;

2. Opioid Analgesics prescribed to a Covered Person who has been diagnosed with a Terminal Condition, but is not a Hospice Patient in a Hospice Care Program; or

Opioid Analgesics prescribed to a Covered Person who has cancer or another condition associated with the Covered Person's cancer or history of cancer.

Covered Persons prescribed Opioid Analgesics for Acute and/or Chronic Pain may be subject to other utilization review measures as determined by us, including care coordination for individuals with substance use disorders.

Orally Administered Chemotherapy

Benefits for orally administered cancer chemotherapy will not be less favorable than the Benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.

Supply, Dose, Duration or Quantity Limits

Some Prescription Drugs are subject to limits that may restrict the amount dispensed per prescription order, refill, time period, total quantity or total dose. To determine if a Prescription Drug has been assigned a maximum limit for dispensing, either visit our website or call Member Services. CareSource may change the limit of a Prescription Drug at any time.

If a Brand-name Drug Becomes Available as a Generic Drug

If a Brand-name Drug becomes available as a Generic Drug, the tier placement of the Brand-name Drug may change or the Brand may no longer be covered. If the Brand drug is covered but a Generic Drug is available, your Copayment or Coinsurance may change. You will pay the Copayment or Coinsurance applicable for the tier to which the Prescription Drug is assigned. If you or your Physician want to continue using the same Brand-name Drug when a Generic Drug is available, the Brand-name Drug may no longer be covered. If the Drug is covered the Copayment or Coinsurance will be applied, which may be higher than the Copayment or Coinsurance for the Generic drug depending on the tier placement of the Generic Drug and the Brand-name Drug. In

addition, you will have to pay the difference between the cost of the Brand-name Drug and the Generic Drug. This difference, called a "Dispense As Written Penalty" or "DAW Penalty" will apply to your Deductible or Out-of-Pocket Maximum expense accumulations.

In the event that a drug which is not covered on the Formulary is granted as a covered service due to a determination of Medical Necessity, you will be responsible to pay the highest applicable copay. Additionally if the exception is made for a drug which takes a DAW Penalty, then you will be responsible for the cost difference between the Brand-name Drug and the Generic Drug. This cost difference will apply to your Deductible or Out-of-Pocket Maximum.

Prescription Drugs Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed under Section 6: *What Is Not Covered* also apply to this section. In addition, the following Exclusions apply.

Medications that are:

- Prescription Drugs not on the Prescription Drug Formulary and that do not meet all requirements for Medical Necessity and the Medical Necessity for Non-Formulary policy.
- Not approved by the Food and Drug Association
- Dispensed with a date of service outside of your coverage eligibility.
- For any condition, Injury, Sickness or Behavioral Health Disorder arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a Claim for such benefits is made or payment or benefits are received;
- A Prescription Drug for which payment or benefits are 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;
- Pharmaceutical products for which Benefits are provided under the medical portion of this EOC (Section 4: *Your Covered Services*);
- An available over-the-counter drug that does not require a prescription order or refill by federal or state law before being dispensed, unless (1) we have designated the over-the-counter drug as eligible for coverage as if it were a Prescription Drug or the over-the-counter drug is classified as a Preventive Health Care Service and (2) it is obtained with a prescription order or refill from a Physician and (3) is available on the Prescription Drug Formulary;
- Prescription Drugs that are available in over-the-counter form or are comprised of components that are available in over-the-counter form or equivalent. This Exclusion does not apply to over-the-counter products that we are required to cover under federal law that are mandated as a Preventive Health Care Service;
- Certain Prescription Drugs that we have determined are Therapeutically Equivalent to an over-the-counter drug. This Exclusion does not apply to over-the-counter products that we

are required to cover under federal law that are mandated as a Preventive Health Care Service;

- Compounded drugs that do not contain at least one ingredient that has been approved by the United States Food and Drug Administration which is on the Prescription Drug Formulary, and requires a prescription order or refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one covered ingredient that requires a prescription order or refill are assigned to the highest applicable copay, or Tier 3);
- Compounded drugs that are commercially available in a different form to treat the same disorder, unless the compounded dosage form and it's components meet all standards of Medical Necessity and contains covered Drugs that cannot be administered through another commercially available product.
- Dispensed by a Pharmacy that is a Non-Network Provider;
- Dispensed outside of the United States, unless dispensed as part of Emergency Health Care Services or Urgent Care Services;
- Durable Medical Equipment (prescribed and non-prescribed Outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered on the Prescription Drug Formulary);
- Dispensed in an amount (days' supply or quantity or dose limit) which exceeds the supply limit;
- Prescribed, dispensed, or intended for use during an Inpatient Stay;
- Prescribed, dispensed, or intended for use during a Skilled Nursing Stay.
- Prescribed for appetite suppression and other weight loss products;
- Prescribed for hyperhidrosis
- Prescribed for sexual dysfunction as a primary diagnosis
- Prescription Drugs, including new Prescription Drugs or new dosage forms, that CareSource determines do not meet the definition of a Covered Service;
- Prescription Drugs that contain an active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug;
- Typically administered by a qualified Provider or licensed health professional in an Outpatient setting. This Exclusion does not apply to Depo Provera and other injectable drugs used for contraception which may be covered according to the Prescription Drug Formulary;
- Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless CareSource has agreed to cover an Experimental or Investigational or Unproven Service, as defined in Section 13: *Glossary*;
- Used for Cosmetic Procedures or purposes;

- For growth hormone therapy to treat familial short stature. (This Exclusion does not apply to growth hormone therapy which is Medically Necessary, as determined by CareSource, to treat a diagnosed medical condition other than familial short stature);
- Used for treatment of onchomycosis; and
- Fertility drugs unless used to treat the medical condition that results in infertility.
- Drugs considered as natural or homeopathic remedies, medical foods, herbal remedies or supplements, naturopathic therapies, complementary medicines, or alternative medicines.

Prescription Drug Exception Process

As required by federal law, CareSource has in place an exception process that allows you, or your Provider to request Benefits for Prescription Drugs, including contraceptives, that are not covered by the Plan's formulary. The exception process is described below, and it only applies to Prescription Drugs, including contraceptives. This process is distinct from the appeal process described in Section 8: *Complaint Process, Claims Procedures and Adverse Benefit Determination Appeals*.

NOTE: If a Prescription Drug exception is granted, the Prescription Drug will be treated as an Essential Health Benefit subject to all applicable Copayments, Coinsurance, and Annual Deductible requirements of your Plan. Your cost of the Prescription Drug will count towards your Annual Out-of-Pocket Maximum.

NOTE: For contraceptives only, the Plan will defer to your attending Provider's recommendation of medical necessity and will provide the contraceptive service or FDA approved item without cost sharing upon request.

NOTE: Drugs listed in "Exclusions" are exclusions to coverage and are not eligible for Medical Necessity review.

Step 1 – Standard or Expedited Internal Review

Standard Internal Review

If we deny Benefits for a Prescription Drug, you, or your Provider may request that we consider an exception either verbally or in writing following the date of our notification of the denial. With your consent, such request may also be submitted on your behalf by your Authorized Representative or by the Provider who prescribed such Prescription Drug. We shall provide you with verbal notification of our determination as expeditiously as your health condition requires but will use good faith efforts to provide you with verbal notification of its decision within seventy-two (72) hours after your request was received by us. If your request for the Prescription Drug is approved pursuant to this paragraph, then we will provide coverage of the Prescription Drug for the duration of the stated Authorization period. If your request is denied, written notification will explain how you may request an independent review of our internal review determination.

Expedited Internal Review

If you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or if you are undergoing a current course of treatment using a non-Formulary Prescription Drug, you or your prescribing Physician may request an expedited internal review for such urgent circumstances. We will provide you with notification of our determination within twenty-four (24) hours after your request was received by us. If your request for the Prescription Drug is approved pursuant to this paragraph, then we will provide coverage of the Prescription Drug or contraceptive for the duration of the stated Authorization period. If your request is denied, written notification will explain how you may request an independent review of our internal review determination.

Step 2 – External Review

If we deny your request for an exception in the Internal Review process described above, you may request either verbally or in writing that an External Review of our determination be conducted. With your consent, such request may also be submitted on your behalf by your Authorized Representative or by the Provider who prescribed such Prescription Drug. For more information on the External Review process, please refer to Section 8: *Complaint Process, Claims Procedures and Adverse Benefit Determination Appeals*.

SECTION 6 – WHAT IS NOT COVERED

This section includes information on:

- Exclusions; and
- Limitations

Benefit Limitations

Benefit limits are listed in your Schedule of Benefits or Section 4: *Your Covered Services*. Limitations may also apply to some Covered Services that fall under more than one Covered Service category. Please review all limits carefully. We will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits. When we say "this includes" or "including," it is not our intent to limit the description to that specific list, but, rather, to provide examples. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

For Covered Services subject to a visit or day limit, when covered by the Plan, they will be calculated against that maximum Benefit limit. The remaining available Benefit instances will be reduced by the number of days/visits used.

Note: Basic Health Care Services, which would otherwise be Covered Services under the Plan, will not be excluded because they were the result of a complication from a Non-Covered Service.

Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section. All Exclusions listed in this section apply to you. The services, treatments, items or supplies listed in this section are not Covered Services unless they are listed as a Covered Service in Section 4: *Your Covered Services* or through a Rider/Enhancement or Amendment to this EOC.

We do not provide Benefits for the following Health Care Services that are:

- Listed as an Exclusion in this EOC.
- Not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or Benefit policy guidelines.
- Except for Emergency Health Care Services, Health Care Services received from a Non-Network Provider unless authorized by us.
- Received from an individual or entity that is not recognized by us as a Provider, as defined in this EOC.
- Health Care Services rendered while you are incarcerated if the Sickness or Injury for which the Health Care Services were rendered resulted from an action or omission for which the governmental entity operating the correctional facility, or the governmental entity with which the law enforcement officer is affiliated, is liable.

- Experimental or Investigational Services. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be an Experimental or Investigational Service. Please refer to the Experimental or Investigational Services Exclusion section, below, for further information on how we determine whether a service is Experimental or Investigational.
- Received to treat any condition, disease, defect, ailment, or Injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this Exclusion does not apply. This Exclusion applies if you receive Workers' Compensation Act benefits in whole or in part. This Exclusion also applies whether or not you Claim the benefits or compensation. It also applies whether or not you recover compensation from any Third Party.
- Provided to you as benefits by any governmental unit, unless otherwise required by law or regulation.
- Health Care Services other than Basic Health Care Services that are received to treat a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- For court ordered testing or care unless Medically Necessary.
- Health Care Services for which you have no legal obligation to pay in the absence of this or like coverage.
- For the following Provider charges listed below:
    - For consultations by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member, except as otherwise described in this EOC. Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for your care.
    - Charges that are not documented in Provider records.
    - Charges from an outside laboratory or shop for services in connection with an order involving devices that are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
    - For membership, administrative, or access fees charged by Providers. Examples of administrative fees include, fees charged for educational brochures or calling you to provide your test results.
- Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- Prescribed, ordered or referred by or received from a member of your immediate family.
- For completion of Claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.

- For any travel related expenses, except as authorized by us or specifically stated as a Covered Service.
- For Health Care Services received prior to the date your coverage began under this EOC.
- For Health Care Services received after the date your coverage terminates.
- For Health Care Services provided in connection with Cosmetic Procedures or cosmetic services. Cosmetic Procedures and cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No Benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).
- For Health Care Services other than Basic Health Care Services to treat complications related to a Cosmetic Procedure, as determined by the Plan. This Exclusion applies even if the original Cosmetic Procedure was performed while the Covered Person was covered by another policy, plan or other benefit program when the original Cosmetic Procedure was performed.
- For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement. Maintenance therapy does not include services classified as Habilitative Services.
- Charges for the following:
  - Custodial Care, convalescent care or rest cures.
  - Domiciliary Care provided in a residential institution, treatment center, halfway house, or school because your own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
  - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
  - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
  - Wilderness camps.
- For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- For routine foot care, including the cutting or removing of corns and calluses; nail trimming, cutting or debriding, hygienic and preventive maintenance foot care, including:
  - Cleaning and soaking the feet.
  - Applying skin creams in order to maintain skin tone.

  - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

- For weight loss programs unless specifically listed as covered in this EOC. This Exclusion includes commercial weight loss programs and fasting programs.
- For bariatric surgery, regardless of the purpose it is performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery, Gastroplasty, or gastric banding procedures.
- For Health Care Services other than Basic Health Care Services to treat complications related to bariatric surgery, including Health Care Services that result in an Inpatient Stay or an extended Inpatient Stay, as determined by us. This Exclusion applies when the bariatric surgery was not a Covered Service under this Plan. This exclusion also applies even if the bariatric surgery was performed while the Covered Person was covered by another policy, plan or other benefit program when the bariatric surgery was performed.
- For marital counseling.
- For biofeedback.
- For work place / hiring physicals; this exclusion shall not apply to those Health Care Services for which Benefits have not been exhausted.
- For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service in Section 4: *Your Covered Services.*
- For vision orthoptic training except as otherwise specifically stated as a Covered Service in Section 4: *Your Covered Services*.
- For hearing aids or examinations to prescribe or fit them, unless otherwise specifically stated as a Covered Service in Section 4: *Your Covered Services*.
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- For Health Care Services and associated expenses for Assisted Reproductive Technology (ART) including but not limited to: artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures or any other treatment or procedure designed to create a Pregnancy. This includes any related prescription medication treatment; embryo transport; donor ovum and semen and related costs, including collection and preparation.
- For the reversal of surgical sterilization.
- For cryo-preservation and other forms of preservation of reproductive materials.
- For long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
- For an abortion, except a Therapeutic Abortion as defined in Section 13: *Glossary*.
- For services and materials not meeting accepted standards of optometric practice.
- For visual therapy.

- For special lens designs or coatings other than those described in this EOC.
- For replacement of lost/stolen eyewear.
- For non-prescription (Plano) lenses.
- For two (2) pairs of eyeglasses in lieu of bifocals.
- For insurance of contact lenses, except as explained herein.
- For personal hygiene, environmental control, or convenience items including but not limited to:
  - Air conditioners, humidifiers, air purifiers;
  - Personal comfort and convenience items during an Inpatient Stay but not limited to daily television rental, telephone services, cots or visitor's meals;
  - Charges for non-medical self-care except as otherwise stated;
  - Purchase or rental of supplies for common household use, such as water purifiers;
  - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
  - Infant helmets to treat positional plagiocephaly;
  - Safety helmets for neuromuscular diseases; or
  - Sports helmets.
- For health club memberships, health spas, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Provider.
- For telephone consultations or consultations via electronic mail or web site, except as required by law, authorized by us, or as otherwise described in this EOC.
- For Health Care Services received in an Emergency Room which are not Emergency Health Care Services, except as specified in this EOC. This includes, but is not limited to suture removal in an Emergency Room.
- For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
- For self-help training and other forms of non-medical self-care.
- For examinations relating to research screenings.
- For stand-by charges of a Provider.
- For physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes; this Exclusion shall not apply to those Health Care Services for which Benefits have not been exhausted or that have not been covered by another source.

- For private duty nursing services rendered in a Hospital or Skilled Nursing Facility. Private duty nursing services are Covered Services only when provided through the Home Health Care Services Benefit as specifically stated in Section 4: *Your Covered Services.*
- For services and supplies related to the primary diagnosis of male or female sexual or erectile dysfunction or inadequacies. This exclusion includes sexual therapy and counseling, penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of a primary diagnosis of impotency, and all related diagnostic services.
- For services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
- For any services or supplies provided to a person not covered under this EOC in connection with a surrogate Pregnancy.
- For surgical treatment of gynecomastia.
- For treatment of hyperhidrosis (excessive sweating).
- For human growth hormone for children born small for gestational age.
- For drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are Therapeutically Equivalent to an over the counter drug, device, product, or supply; this exclusion shall not apply to drugs prescribed as Preventive Health Care Services.
- For sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
- For treatment of telangiectatic dermal veins (spider veins) by any method.
- For reconstructive services except as specifically stated in the Your Covered Services section of this EOC, or as required by law.
- For nutritional and/or dietary supplements, except as provided in this EOC or as required by law. This Exclusion includes: those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed Pharmacist.
- Not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible Covered Services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law.

- For all adult dental treatment except as specified elsewhere in this EOC. "Dental treatment" includes: preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that temporomandibular disorders (TMJ) and craniomandibular disorders (CMD) are Covered Services) or gums, including but not limited to:
  - Extraction, restoration and replacement of teeth.
  - Medical or surgical treatments of dental conditions for adults.
  - Services to improve dental clinical outcomes.
- For adults - treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
- For dental implants for adults.
- For dental braces for adults.
- For adults - dental x-rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:
  - Transplant preparation.
  - Initiation of immunosuppressives.
  - Direct treatment of acute traumatic Injury, cancer or cleft palate.
- For treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.
-

Experimental or Investigational Services Exclusion

Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, Illness, or other health condition which we determine to be Experimental or Investigational is not covered under the Plan.

We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if we determine that one or more of the following criteria apply when the service is rendered with respect to the use for which coverage is sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- Cannot be legally marketed in the United States without the final approval of the United States Food and Drug Administration, or other licensing or regulatory agency, and such final approval has not been granted; or
- Has been determined by the United States Food and Drug Administration to be contraindicated for the specific use; or

- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental or Investigational based on the criteria above may still be deemed Experimental or Investigational by us. In determining whether a Health Care Service is Experimental or Investigational, we will consider the information described below and assess whether:

- The scientific evidence is conclusory concerning the effect of the service on health outcomes;
- The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the United States Food & Drug Administration or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Documents of an institutional review board or other similar body performing substantially the same function; or

- Consent document(s) and/or the written protocol(s) used by your Providers studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

We have the sole authority and discretion to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

SECTION 7 – STAYING HEALTHY

Healthy Living/Care and Disease Management Programs

We offer disease management programs for Covered Persons who have specific health conditions, such as diabetes and asthma. These programs are voluntary and are available at no cost to you. Disease management programs can provide important value. New services may be added and existing services may be modified or eliminated at any time. Please visit our website or contact Member Services for more information regarding our health management programs.

What this section includes:

Health and well-being resources available to you, including

- Consumer Solutions and Self-Service Tools; and
- Care and Disease Management Services.

CareSource believes in giving you the tools you need to be an educated health care consumer. We have made available several convenient educational and support services, accessible at CareSource.com, which can help you to:

- Take care of yourself;
- Manage a chronic health condition; and
- Navigate the complexities of the health care system.

NOTE:

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. CareSource is not responsible for the results of your decisions from the use of the information, including, but not limited to, your choice to seek or not to seek professional medical care, or your choice of specific treatment, or not, based on the text.

CareSource24®

Health worries don't always happen during Business Hours. Our experienced nurses are available through CareSource24®, our 24 hour nurse advice line, to talk about any health problem that concerns you. Call us if you have questions, need advice or if you are wondering where the best place to receive care might be. You will find the CareSource24® toll-free number on your member ID Card. We can help you decide if you can care for yourself or a sick family member at home or if you should seek help from a medical professional. Please remember to call 911 if you are experiencing an Emergency Medical Condition.

Care4U Care Coordination

If you have a serious or complicated health problem, including a substance use disorder, we are here to help you navigate through the health care system to get the coordinated, quality care you need. Our experienced care coordination team works with you and your doctor to make certain you are getting the best care possible. We do the coordination for you so that you can concentrate on your health.

Care4U Care Transitions

If you are hospitalized, our free care transitions program helps coordinate the care you need to safely go home after your stay. Our experienced care coordination team works with you and your provider to make certain you get the care you need when you return home. We help you set goals that will help you feel better and make certain you are taking the medicine you need, when you need it. We also work to make sure that you understand your care and who to call when the doctor's office is closed. Our program is here to make coming home from the hospital as smooth as possible for you and your family.

Reminder Programs

To help you stay healthy, CareSource may send you reminders to schedule recommended screening exams. Examples of reminders may include:

- Mammograms;
- Child and adolescent immunizations;
- Cervical cancer screenings;
- Comprehensive screenings for individuals with diabetes; and
- Influenza/pneumonia immunizations.

There is no need to enroll in this program. You will receive a reminder automatically if our records show you have not had a recommended screening exam.

Medication Therapy Management Program

At CareSource, we believe it is critical that you take your medications correctly and are on the right medications for your health conditions. We offer the Medication Therapy Management Program (MTM) as a program free of charge to help you do just that. We encourage you to meet with your pharmacist and discuss your medications. Your pharmacists are available for consultation and we encourage them to do so as part of our program.

Your pharmacist can help with:

- Review of all your prescriptions and over-the-counter medications
- Education on how to use medications correctly
- Identifying medications that may interact with each other
- Identifying medications that may help you save money

CareSource Online

The CareSource Member website, CareSource.com/marketplace, provides information at your fingertips anywhere and anytime you have access to the Internet. Our website opens the door to a wealth of health information and convenient self-service tools to meet your needs.

On our website, you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician;
- Search for Network Providers available in your Plan through the Find A Doctor lookup tool, which is available at CareSource.com;
- Complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources.
- Find tools, education and resources, including support groups and crisis numbers to assist with treatment for opioid use and other substance use disorders.

MyCareSource®

Set up your personal online account at MyCareSource.com. The enrollment process is quick and easy and provides private, secure access to your health information, plan documents, services, and more. Have your CareSource ID card handy.

Visit MyCareSource.com to:

- Access and print, or order a new or replacement ID Card after your first payment is received
- View eligibility and benefit information, including Copayments and Annual Deductibles;
- Find an in network provider, including specialists, hospitals, and more
- View and pay your invoice or set up automatic payments
- See the current status and history of your Claims
- Take a health risk assessment and get a customized wellness plan;

Want to learn more about a condition or treatment?

Visit our website and research health topics that are of interest to you. Learn about a specific condition, the symptoms, how it is diagnosed, how common it is, and what to ask your Physician.

SECTION 8 – COMPLAINT PROCESS, CLAIMS PROCEDURES AND ADVERSE BENEFIT DETERMINATION APPEALS

What this section includes:

- What to do if you have a Complaint;
- How to request Prior Authorizations, Predeterminations, and Medical Reviews; and
- How to Appeal Adverse Benefit Determinations.

Please contact Member Services at 1-800-479-9502 with any questions you have about your Benefits, including any questions about your coverage and Benefit levels, Annual Deductibles, Coinsurance, Copayment and Annual Out-of-Pocket Maximum amounts, specific claims or services you have received, our Network, and our authorization requirements.

While we hope that there are no problems with our services to you, we have implemented (1) the Complaint Process, (2) the Internal Appeals Process, and (3) the External Review Process. These processes are intended to provide fair, reasonable, and timely solutions to issues that you may have concerning CareSource, the Plan, Benefit determinations, coverage and eligibility issues, or the quality of care rendered by Network Providers.

The Complaint Process

We have put in place a Complaint Process for the quick resolution of complaints you submit to us that are unrelated to the Plan's decision to deny, reduce, or terminate coverage for Health Care Services. For purposes of this complaint process, we define a complaint as an expression of unhappiness or dissatisfaction relating to any aspect of our operation. If you have a complaint concerning us, please contact us.

You, or an Authorized Representative, may submit your complaint by sending a letter to us at the following address: CareSource, Attention: Ohio Member Appeals, P.O. Box 1947, Dayton, OH 45401. Fax: 937-487-0629. Expedited Fax: 937-396-3030. You may also submit a Complaint by calling Member Services at 1-800-479-9502. You may arrange to meet with us in-person to discuss your complaint.

Within thirty (30) calendar days of our receipt of your complaint, we will investigate, resolve, and respond to the complaint and send you a letter explaining our resolution of the Complaint.

NOTE: The Adverse Benefit Determination Appeal Process below addresses issues related to Adverse Benefit Determinations, which include Benefits Denials. The Adverse Benefit Determination Appeal Process, described below, is separate and distinct from the Complaint Process.

Definitions

For purposes of this section only, the following definitions apply—

Adverse Benefit Determination means a decision by CareSource to deny, reduce, or terminate a requested Health Care Service or Benefit in whole or in part, including all of the following:

- A determination not to issue you coverage, if applicable to this Plan;
- A determination of your eligibility for Benefits under the Plan;
- A determination that a Health Care Service is not a Covered Service;
- The imposition of an Exclusion or other limitation on Benefits that would otherwise be covered;
- A determination that the Health Care Service does not meet the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational Services; or
- A Rescission of coverage under the Plan regardless of whether there is an adverse effect on any particular Benefit at that time.

Authorization - A determination by us that a Health Care Service has been reviewed and, based upon the information provided to us, are Covered Services.

Coverage Denial means a determination by us that a service, treatment, drug, or device is specifically limited or excluded under a Covered Person's Plan.

External Review means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to State or federal law.

Final Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by us at the completion of the internal appeals process described in this Section.

Independent Review Entity (or IRE) means an entity that conducts Independent External Reviews of Adverse Benefit Determinations.

Internal Appeal means the review by us of an Adverse Benefit Determination.

Predetermination - An Authorization that you voluntarily request prior to or during the course of receiving a Health Care Service. We will review your EOC to determine if there is an Exclusion for the Health Care Service. If there is a related clinical coverage guideline, then the benefit coverage review will include a review to determine whether the Health Care Service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.

Retrospective Medical Review - A review of whether a Health Care Service that has already been received is a Covered Service. A review may only be deemed a Retrospective Medical Review if our Prior Authorization was not required and a Predetermination review was not performed.

Retrospective Medical Reviews are typically initiated by us. Retrospective Medical Reviews do not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

Initial Benefit Determinations

In processing Claims, we review requests for (1) Prior Authorization, (2) Predetermination, and (3) Retrospective Medical Review to determine whether the requested Benefits are Covered Services. This process is described below. If you have any questions regarding the information contained in this section, you may call Member Services at 1-888-815-6446.

Most Network Providers know which services require Prior Authorization and should obtain any required Prior Authorization or request a Predetermination if they feel it is necessary. The ordering Network Provider will contact us to request Prior Authorization or a Predetermination review. We will work directly with your Network Provider regarding such Prior Authorization request. However, you may designate an Authorized Representative to act on your behalf for a specific request.

We will utilize our clinical coverage guidelines in determining whether Health Care Services are Covered Services. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, please contact Member Services.

Types of requests for Prior Authorization, Predetermination, and Retrospective Medical Review:

Urgent Review Request - A request for review of any Claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (1) could seriously jeopardize the life, health or safety of the member or others as a result , (2) could seriously jeopardize the life, health, or safety of the member or others due to the member's psychological state, (3) in the opinion of a Physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care of treatment that is subject of the review, or (4) in the opinion of a Physician with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request. In addition, a Claim involving urgent care also includes any Claim that a Physician with knowledge of the member's condition determines is a Claim involving urgent care. All requests for opioid use treatment will be treated as an Urgent Review Request.

Prospective Urgent Review Request Submitted Through Secure Electronic Transmission - A request for Prior Authorization or a Predetermination submitted prior to you receiving a Health Care Service with respect to which the application of the time periods for making non-urgent care prospective determinations: (1) could seriously jeopardize the life, health or safety of the member or others as a result , (2) could seriously jeopardize the life, health, or safety of the member or others due to the member's psychological state, (3) in the opinion of a Physician with knowledge

of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care of treatment that is subject of the review, or (4) in the opinion of a Physician with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request. In addition, a Claim involving Urgent Care Services also includes any Claim that a Physician with knowledge of the member's condition determines is a Claim involving urgent care.

Prospective Review Request - A request for Prior Authorization or a Predetermination that is submitted before you receive a Health Care Service.

Concurrent Review Request - A request for Prior Authorization or a Predetermination that is submitted before or during the course of receiving a Health Care Service.

Retrospective Review Request - A request for Medical Review that is submitted after the Health Care Service has been received.

Timing of Initial Benefit Determinations

We will make our benefit decisions within the timeframes listed below. Please call Member Services at 1-800-479-9502 with any questions you may have.

Review Request Category	Timeframe for Making Decision
Urgent Care Reviews*	As soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours from the receipt of request.
Prospective Urgent submitted through Secure Electronic Transmission**	As soon as possible, taking into account the medical exigencies, but not later than forty-eight (48) hours from the receipt of the request.
Prospective Care Reviews	Within two (2) Business Days after receiving all necessary information, or fifteen (15) calendar days from the receipt of the request, whichever is less.
Prospective submitted through Secure Electronic Transmission	Within two (2) Business Days after receiving all necessary information or within ten (10) calendar days from the receipt of the request, whichever is less.
Concurrent Urgent, when request is received at least twenty-four (24) hours before the expiration of the previous authorization or no previous authorization exists.	Within twenty-four (24) hours from the receipt of the request, taking into account the medical exigencies.
Concurrent Urgent, when request is received less than twenty-four (24) hours before the expiration of the previous authorization or no previous authorization exists.	As soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours from the receipt of request, whichever is less.
Concurrent	Within one (1) Business Day after receiving all necessary information.

Retrospective Care Reviews***	Within thirty (30) calendar days of our receipt of your request.

* The timeline above for Urgent Care Reviews does not apply if we do not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan. If we need more information before we can make a decision, we will notify you and your Provider of the information we need within twenty-four (24) hours of our receipt of your request. You and your Provider will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. We will notify you of our final decision as soon as possible, but in no case later than forty-eight (48) hours after the earlier of: (a) our receipt of the specified information, or (b) the end of time period afforded to you to provide the specified additional information.

** **Prospective Urgent Care Claims through Secure Electronic Transmission.** If we need more information before we can make a decision, we will notify you of the information we need within twenty-four (24) hours of our receipt of your request. We will notify you of our final decision as soon as possible, but in no case later than forty-eight (48) hours after we received your request.

*** The timeline above for Retrospective Care Reviews does not apply if we do not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan or due to matters beyond our control. If we need more information before we can make a decision, then we will notify you within thirty (30) days from receipt of the request. The notice will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice in which to provide the specified information. This thirty (30) day period may also be extended one time by us, for up to fifteen (15) days, if we determine that such an extension is necessary due to matters beyond our control and notify you, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the we expect to render a decision.

Notification of Initial Benefit Determinations

We will provide notification of our decision in accordance with state and federal regulations. Notification may be given to the Covered Person or his or her Provider by mail or another means of communication.

NOTE: Prior to providing notification to you via electronic means, we will obtain advanced written consent from you or your Authorized Representative.

If we approve your request for Benefits or Health Care Services, we will provide you with notice of our decision. However, even if we give Prior Authorization for Health Care Services, such Prior Authorization does not guarantee that the Plan will provide Benefits for such Health Care Service. In order for the Plan to provide Benefits for the Health Care Service at issue:

- You must be eligible for coverage under the Plan;
- The Health Care Service must be a Covered Service;
- You may not have exceeded any applicable limits described in this EOC; and

- The Health Care Service may not be subject to an Exclusion under the Plan.

If we deny your request for Benefits or Health Care Services, we will provide you or your Authorized Representative with an Adverse Benefit Determination notice.

Reconsideration of Adverse Benefit Determination

For Adverse Benefit Determinations related to Concurrent Service Requests or Prospective Service Requests, your Provider or Health Care Facility rendering the Health Care Service may request – in writing on your behalf – a reconsideration of the Adverse Benefit Determination by conducting a peer-to-peer review. The Provider or Health Care Facility may not request reconsideration without your prior written consent.

The reconsideration shall occur within three (3) Business Days after we receive the written request for reconsideration, and shall be conducted between the Provider or Health Care Facility rendering the Health Care Service and the reviewer who made the Adverse Benefit Determination; however, if our reviewer is not available, the reviewer may designate another reviewer. We will reconsider the Adverse Benefit Determination within three (3) Business Days after we receive the request for reconsideration. For requests for reconsideration related to an Urgent Care Review, we shall review such request in a timeframe that takes into account the medical urgency. Reconsideration is not required before you pursue an Internal or External Review of an Adverse Benefit Determination. Your Provider must have your written consent in order to conduct this peer-to-peer review with the Plan's reviewer or the Plan's designee.

Internal Appeal Process

You have the right to file an Internal Appeal with us if you disagree with or are dissatisfied with our decision concerning any of the review requests listed above. Your Internal Appeal may be submitted by you or your Authorized Representative. The timing of decisions and notifications related to such Internal Appeals are provided below.

Adverse Benefit Determination Appeals

Your Plan offers one (1) level of Internal Appeal.

If you or your Authorized Representative wish to appeal an Adverse Benefit Determination, then you or your Authorized Representative must submit your Internal Appeal to us within one hundred eighty (180) days of receiving the Adverse Benefit Determination. All Internal Appeal requests must be in writing, except for an Internal Appeal request involving Urgent Care, which may be requested orally or electronically.

You or your Authorized Representative may send a written request for an Internal Appeal to:

CareSource, Attention: Ohio Member Appeals, P.O. Box 1947, Dayton, OH 45401. Fax: 937-487-0629. Expedited Fax: 937-396-3030.

If you or your Authorized Representative would like to appeal a denied Urgent Care Review, then you may submit your Internal Appeal orally by calling us at 1-800-479-9502.

Your request for an appeal of an Adverse Benefit Determination must include the following information:

1. The Covered Person's name and identification number as shown on the ID Card;
2. The Provider's name;
3. The date of the Health Care Service;
4. The reason you disagree with the Adverse Benefit Determination; and
5. Any documentation or other written information to support your request.

Standard Review of an Internal Appeal

The Internal Appeal of an Adverse Benefit Determination will be reviewed by a health care Provider not involved in the initial decision, which is in the same or similar specialty that typically manages the medical or dental condition, procedure, or treatment under review. The Physician or Provider reviewing the Internal Appeal will take into account all records and information submitted by the Covered Person or the Covered Person's Authorized Representative relating to the Claim, and may interview the patient or patient's designated representative, or Provider, as appropriate.

The Internal Appeal of a Coverage Denial will be processed by us in accordance with applicable law and standard operating procedures.

We may need additional information to process a request for an Internal Appeal. If additional information is needed, then we may send to you or your Authorized Representative a letter acknowledging the date we received the request for an Internal Appeal and a list of documents, if any, you or your Authorized Representative must submit. Upon your request, we will provide you with any new or additional evidence considered, relied upon, or generated by us in determining your Internal Appeal.

All Standard Internal Appeals will be reviewed by a clinical peer. In addition, Internal Appeals for Prospective Review denials will be between the clinical peer and the requesting Provider to the extent the requesting Provider is available.

The Plan must notify you of the Internal Appeal determination within ten (10) calendar days after receiving the Internal Appeal for a Prospective Review or Step Therapy exemption denial and thirty (30) calendar days after receiving the Internal Appeal for all other denials.

If we deny your Internal Appeal, then we will notify you via a Final Adverse Benefit Determination notice. If we approve your request for benefits, then we will provide you, your attending Physician, or ordering Provider with the appropriate notice.

Expedited Review of an Internal Appeal

You may request an expedited review of an Internal Appeal of an Adverse Determination for:

- Any request for Health Care Services when the time periods for making non-Urgent Review Request determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function, or
- In the opinion of a Physician with knowledge of your medical or behavioral condition, would subject you to severe pain or adverse health consequences that cannot be adequately managed without the care or treatment that is the subject of the request.
    - Except as provided below, whether a request meets the above conditions in order to be eligible for an expedited Internal Appeal will be determined by an individual acting on behalf of CareSource applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine.

- Any request that a Physician with knowledge of your medical condition determines is a request involving Urgent Care Services.

All Expedited Internal Appeals will be reviewed by a clinical peer. In addition, Expedited Internal Appeals for Prospective Review denials will be between the clinical peer and the requesting Provider to the extent the requesting Provider is available.

If the expedited clinical appeal fails to meet expedited criteria, you or your Authorized Representative will be contacted via telephone and in writing advising that the matter does not meet expedited criteria and will be handled under the standard Internal Appeal process. However, if your physician with knowledge of the your condition indicates that the appeal must be processed as expedited, CareSource will render an expedited decision. A follow-up letter is sent to you within twenty-four (24) hours confirming the matter does not meet expedited criteria and providing expedited grievance rights. The matter is then transferred to the standard Internal Appeal process

We will complete an expedited review of an Internal Appeal as soon as possible given your medical needs, but no later than forty-eight (48) hours after receipt of your request for an Expedited Internal Appeal involving a Prospective Review or Step Therapy exemption denial or seventy-two (72) hours after our receipt of the request for Expedited Internal Appeal for all other denials. We will communicate our decision and all other necessary information by telephone to you, your attending Physician or the ordering Provider.

If our decision is still adverse to you, we will also provide a Final Adverse Benefit Determination notice to you, your attending Physician or ordering Provider. The notice will include the same or similar information to that provided in a notice of non-expedited Internal Appeal. If we approve your request for benefits, then we will also provide you, your attending Physician, or ordering Provider with the appropriate written notice.

Exhaustion of the Internal Appeals Process

The Internal Appeal process must be exhausted prior to initiating an External Review – except in the following instances:

- We agree to waive the exhaustion requirement;

- You did not receive a written decision of the Internal Appeal within the required time frame;
- We failed to meet all requirements of the Internal Appeal process. This exception does not apply if (1) the failure was minor and did not cause – and is not likely to cause – prejudice or harm to you; (2) we demonstrate that the violation was for good cause or due to matters beyond our control; (3) the violation occurred in the context of an ongoing, good faith exchange of information between CareSource and you; or (4) the violation is part of a pattern or practice of violations by us.
- An expedited External Review is sought simultaneously with an expedited Internal Appeal.

External Review Process

External Review of the Final Adverse Benefit Determination Notice

We provide a process that allows you the right to request an independent External Review of an Adverse Benefit Determination notice. You will not pay for the External Review. There is no minimum cost of Health Care Services denied in order to qualify for an External Review; however, you must generally exhaust our Internal Appeal process before seeking an External Review. Any exceptions to this requirement will be included in the notice of Adverse Benefit Determination. You will not be subject to retaliation for exercising your right to request an independent External Review.

An External Review will be conducted by either the Ohio Department of Insurance ("Department") or an Independent Review Organization ("IRO"), depending on the nature of your Internal Appeal.

If your request for an External Review is based on a contractual issue that does not involve a medical judgment or medical information or involves Emergency Health Care Services that have been determined to be not Medically Necessary and the Plan's decision has already been upheld through External Review by an IRO, then the Department will review your External Review.

If your request for an External Review involves medical judgment or medical information or involves experimental or investigational Health Care Services, then an IRO will review your External Review.

Requests for External Review

Regardless of whether the External Review is to be reviewed by an IRO or the Ohio Department of Insurance and regardless of whether it's a standard, expedited, or experimental or investigational External Review request, you or your Authorized Representative must request an External Review through us within one hundred eighty (180) calendar days of the date of the notice of Final Adverse Benefit Determination notice issued by us. All External Review requests must be in writing, except for a request for an expedited External Review, which may be requested orally or electronically. In addition to filing the request for External Review, you will also be required to authorize the release of your medical records as necessary to conduct the External Review. In addition, if you wish to have another person represent you during the External Review process, then you must submit a written authorization appointing that person as your Authorized Representative.

You or your Authorized Representative may send a written request for an External Review to:

CareSource, Attention: Ohio Member Appeals, P.O. Box 1947, Dayton, OH 45401. Fax: 937-487-0629. Expedited Fax: 937-396-3030.

If you or your Authorized Representative would like to file an expedited External Review, then you may submit your request for expedited External Review orally by calling us at 937-487-0629.

Your request for an External Review must include the following information:

1. The Covered Person's name and identification number as shown on the ID Card;
2. The Provider's name;
3. The date of the Health Care Service;
4. The reason you disagree with the Final Adverse Benefit Determination; and
5. Any documentation or other written information to support your request.

If your request for a standard External Review is complete, then the Plan will initiate the External Review process and notify you in writing that the request is complete and eligible for External Review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. The notice also will inform you that, within ten (10) Business Days after receipt of the notice, you may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. We will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRO or the Ohio Department of Insurance (as applicable) within five (5) days after receipt of your request for a standard External Review that is complete and valid. If the request for a Standard External Review is not complete, then we will inform you in writing and specify what information is needed to make the request complete.

If your request for an expedited External Review is complete, then we will initiate the expedited External Review process and immediately notify you that your request is complete and eligible for review. We will also immediately provide (either electronically or by facsimile or other available expeditious methods) all necessary documents and information regarding the Adverse Benefit Determination to the IRO or Ohio Department of Insurance (as applicable). If the request is not complete, then we will contact you immediately and specify what information is needed to make the request complete.

If we determine that the Adverse Benefit Determination is not eligible for External Review, then we must notify you in writing and provide you with the reason for our determination and inform you that the denial may be appealed to the Ohio Department of Insurance. Regardless of any determination made by us, the Ohio Department of Insurance may determine that your request is eligible for External Review and may require that the request be referred for External Review. The Department's decision will be made in accordance with the terms of the Plan and all applicable provisions of the law.

External Reviews Conducted by the Ohio Department of Insurance

The Ohio Department of Insurance will conduct External Reviews in either of the following instances:

- The Adverse Benefit Determination notice is based on a contractual issue that does not involve a medical judgment or medical information; or

The Adverse Benefit Determination notice involves Emergency Health Care Services that have been determined to be not Medically Necessary or appropriate and our decision has already been upheld through an External Review by an Independent Review Organization.

Ohio Department of Insurance Review and Decision

The Department reviews all requests for External Review of Final Adverse Benefit Determinations where the determination made by us was based on a contractual issue and does not involve a medical judgment or a determination based on any medical information. The Department will also review requests for External Review related to Emergency Health Care Services where such Emergency Health Care Services have been determined to not be Medically Necessary and our decision had previously been upheld through an External Review by the IRO. The Department will not conduct a review unless you have exhausted our Internal Appeal process.

You and CareSource will provide the Department with any information required by the Department that is in your possession or our possession and is germane to the review by the Department.

The Department shall determine whether the Health Care Service is a Covered Service. The Department will then notify you and us of its decision. If the Department determines that the Health Care Service is a Covered Service, then we will provide coverage pursuant to the terms of the Plan. If the Department determines that the Health Care Service is not a Covered Service, then we will not be required to cover the service or afford you the opportunity for an External Review by an IRO.

External Review Conducted by Independent Review Organization

IRO Assignment

When we initiate an External Review by an IRO, the Ohio Department of Insurance assigns the review to an accredited IRO that is qualified to conduct the review based on the type of Health Care Service. An IRO that has a conflict of interest with us, you, your Provider, or the Facility will not be selected to conduct the review. The independent review shall be conducted by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for the purposes of the independent review shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

Standard External Reviews Conducted by an IRO

An Independent Review Organization will conduct External Reviews in the following instances:

- The Final Adverse Benefit Determination involves a medical judgment or is based on any medical information; or

- The Final Adverse Benefit Determination indicates the requested Health Care Service is Experimental or Investigational, except when the requested Health Care Service is explicitly listed as an Exclusion under your Plan, and your treating Physician certifies at least one of the following:
  - Standard Health Care Services have not been effective in improving your condition;
  - Standard Health Care Services are not medically appropriate for you; or
  - No available standard Health Care Service covered by us is more beneficial than the requested Health Care Service.

Expedited External Review Conducted by Independent Review Organization

You are entitled to an expedited External Review by an Independent Review Organization in the following instances:

- Your treating Physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal and you filed a request for expedited Internal Appeal.
- Your treating Physician certifies that the Final Internal Adverse Benefit Determination involves a medical condition that could seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed until after the time frame of a standard External Review.
- The Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or Health Care Service for which you received Emergency Health Care Services, but have not yet been discharged from a Facility.
- Your treating Physician certifies that the Adverse Benefit Determination involves experimental or investigational services that would be significantly less effective if not promptly initiated.

NOTE: An expedited External Review is not available for retrospective Final Internal Adverse Benefit Determinations (meaning the Health Care Service has already been provided to you.)

NOTE: Upon receipt of new information from the IRO, we may reconsider our Adverse Benefit Determination and provide coverage. If we reverse an Adverse Benefit Determination, then we will notify you, the IRO, and the Ohio Department of Insurance of our decision within one (1) Business Day.

IRO Review and Decision

The IRO must consider all documents and information considered by us in making the Adverse Benefit Determination, any information submitted by you, and other information such as your

medical records, your attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the Plan, the most appropriate practice guidelines, clinical review criteria used by us or our utilization review organization, and the opinions of the IRO's clinical reviewers. The IRO is not bound by any previous decision reached by us.

The IRO assigned to review your External Review will provide a written notice of its decision to either uphold or reverse our determination within thirty (30) days of receipt by us of a request for a standard External Review or a standard External Review involving an Experimental or Investigational treatment or within seventy-two (72) hours of receipt by us of an expedited External Review.

The IRO determination notice will be sent to you, us, and the Ohio Department of Insurance. The IRO determination notice must include the following information:

- A general description of the reason for the request for External Review;
- The date the IRO was assigned by the Ohio Department of Insurance to conduct the External Review;
- The dates over which the External Review was conducted;
- The date on which the IRO's decision was made;
- The rationale for its decision; and
- References to the evidence or documentation, including any evidence-based standards that were used or considered in reaching its decision.

NOTE: Written decisions of an IRO concerning an Adverse Benefit Determination that involve a Health Care Services that is stated to be Experimental or Investigational will also include the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation as to whether the recommended or requested Health Care Services should be covered and their rationale for the recommendation.

Binding Nature of the IRO Decision

An External Review decision is binding on you and us except to the extent we have other remedies available under stated or federal law or unless the Ohio Department of Insurance determines that, due to facts and circumstances of an External Review, a second External Review is required.

Subject to the foregoing, upon receipt of notice by an IRO to reverse an Adverse Benefit Determination, we will provide coverage for the Heath Care Service in question.

You may not file a subsequent request for an External Review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to us.

A decision issued by the IRO will be admissible in any civil action related to our coverage decision. The IRO’s decision is presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

If You Have Questions About Your Rights or Need Assistance

You may contact us by mail or phone. Please call Member Services at 1-800-479-9502, or send correspondence to CareSource, Attention: Ohio Member Appeals, P.O. Box 1947, Dayton, OH 45401. Fax: 937-487-0629. Expedited Fax: 937-396-3030.

You may also contact the Ohio Department of Insurance at:

Ohio Department of Insurance
ATTENTION: Consumer Affairs
50 West Town Street, Suite 300
Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

Contact ODI Consumer Affairs:

https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp

To file a Consumer Complaint, please go to:

http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

Language Services

If you request language services, then we will provide service in the requested language through bi-lingual staff or an interpreter. If requested, then we will provide language services to help (1) assist you in registering a complaint or appeal, and (2) notify you about your complaint or appeal.

SECTION 9 – COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How your coverage is affected if you become eligible for Medicare; and
- Procedures in the event we overpay Benefits.

This Coordination of Benefits ("COB") section applies if you have health care coverage under more than one Health Plan. "Health Plan" is defined below.

Coordination of Benefits is the process used for determining which health plan or insurance policy will pay first and/or determining the payment obligations of each health plan, medical insurance policy, or third party resource when two or more health plans, insurance policies or third party resources cover the same Benefits for Covered Persons under this Plan.

The Order of Benefit Determination Rules govern the order in which each Health Plan will pay a Claim for benefits. The Health Plan that pays first is called the Primary Health Plan. The Primary Health Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Health Plan may cover some expenses. The Health Plan that pays after the Primary Health Plan is the Secondary Health Plan. The Secondary Health Plan may reduce the benefits it pays so that payments from all Health Plans do not exceed the Primary Health Plan's Allowable Expense.

Definitions

A. A "Health 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 Health Plan and there is no COB among those separate contracts.

(1) Health Plan includes, as permitted by state law: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan.

(2) Health Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental Health Plans, unless otherwise permitted by law.

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

B. "This Health 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 Health Plans. Any other part of the contract providing health care Benefits is separate from This Health Plan. A contract may apply one COB provision to certain Benefits, such as dental Benefits, coordinating only with similar Benefits, and may apply another COB provision to coordinate other Benefits, such as medical benefits.

C. The "Order of Benefit Determination Rules" determine whether This Health Plan is a Primary Health Plan or Secondary Health Plan when the person has health care coverage under more than one Health Plan.

When This Health Plan is the Primary Health Plan, it determines payment for its Benefits first before those of any other Health Plan without considering any other Health Plan's Benefits. When This Health Plan is the Secondary Health Plan, it determines its Benefits after those of another Health Plan and may reduce the Benefits it pays so that all Health Plan Benefits do not exceed 100% of the total Allowable Expense.

D. Allowable Expense is a health care expense, including Annual Deductibles, Coinsurance and Copayments, that is covered at least in part by any Health Plan covering the person. When a Health 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 Health Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a 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 2 or more Health Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(3) If a person is covered by two (2) or more Health 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 Health Plan that calculates its Benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Health Plan that provides its benefits or services on the basis of negotiated fees, the Primary Health Plan's payment arrangement will be the Allowable Expense for all Health Plans. However, if the provider has contracted with the Secondary Health Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Health Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Health Plan to determine its Benefits.

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

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 providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

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

F. Order of Benefit Determination Rules

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

The Primary Health Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

A.

(1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be 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.

B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is Secondary Health Plan to that other Plan.

Each Plan determines its order of Benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Health Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Health Plan and the Health Plan that covers the person as a dependent is the Secondary Health Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Health Plan covering the person as a dependent, and primary to the Health Plan covering the person as other than a dependent (e.g. a retired employee), then the order of Benefits between the two Health Plans is reversed so that the Health Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Health Plan and the other Health Plan is the Primary Health Plan.

(1) Dependent child covered under more than one Health Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Health Plan the order of Benefits is determined as follows:

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

- The Health Plan of the parent whose birthday falls earlier in the calendar year is the Primary Health Plan; or
- If both parents have the same birthday, the Health Plan that has covered the parent the longest is the Primary Health Plan.
- However, if one spouse's Health Plan has some other coordination rule (for example, a "gender rule" which says the father's Health Plan is always primary), we will follow the rules of that Health Plan.

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

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

(ii.) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the

provisions of Subparagraph (a) above will determine the order of Benefits;

(iii.) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of Benefits; or

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

1. The Health Plan covering the Custodial Parent;

2. The Health Plan covering the spouse of the Custodial Parent;

3. The Health Plan covering the non-Custodial Parent; and then

4. The Health Plan covering the spouse of the non-Custodial Parent.

(c) For a dependent child covered under more than one Health Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above will determine the order of Benefits as if those individuals were the parents of the child.

(2) Active employee or retired or laid-off employee. The Health Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Health Plan. The Health Plan covering that same person as a retired or laid-off employee is the Secondary Health 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 other Health Plan does not have this rule, and as a result, the Health Plans do not agree on the order of Benefits, this rule is ignored. This rule does not apply if the rule labeled (1) can determine the order of Benefits.

(3) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Health Plan, the Health 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 Health Plan and the COBRA or state or other federal continuation coverage is the Secondary Health Plan. If the other Health Plan does not have this rule, and as a result, the Health Plans do not agree on the order of Benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of Benefits.

(4) Longer or shorter length of coverage. The Health Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Health Plan and the Health Plan that covered the person the shorter period of time is the Secondary Health Plan.

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

Effect on the Benefits of This Health Plan

When This Plan is the Secondary Health Plan, it may reduce its Benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Health 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 Health Plan. The Secondary Health Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Health Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Health Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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 shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under This Health Plan and other Health Plans. CareSource may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining Benefits payable under This Health Plan and other Health Plans covering the person claiming Benefits. CareSource need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Health Plan must give CareSource any facts it needs to apply those rules and determine Benefits payable.

Facility of Payment

A payment made under another Health Plan may include an amount that should have been paid under This Health Plan. If it does, CareSource 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 Health Plan. CareSource 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 CareSource 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.

Coordination of Benefits

If you believe that we have not paid a Claim properly, you should first attempt to resolve the problem by contacting us. Please call Member Services at 1-800-479-9502. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at http://insurance.ohio.gov.

SECTION 10 – SUBROGATION AND REIMBURSEMENT

What this section includes:

- How your Benefits are impacted if you suffer a Sickness or Injury caused by a Third Party.

Subrogation – Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, we have the right to take legal action in our name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

We may pay Benefits on your behalf for Health Care Services resulting from a Sickness or Injury for which a Third Party is legally responsible to pay. If we pay these Benefits on your behalf, we have the legal right to substitute CareSource for you for the limited purpose of making a claim to recover the Benefits we paid on your behalf.

We also have a legal right to recover from you or a Third Party legally responsible for paying for your treatment, any Benefits payments that we paid on your behalf. We may recover those paid Benefits through reimbursement (if you receive payment from that responsible party), by assignment, or by subrogation.

You must promptly notify us in writing of how, when and where an accident or incident resulting in Sickness or Injury to you occurred and all information regarding the parties involved, including whether you have retained an attorney. Throughout the recovery process, you (or your legal representative) must not do anything to limit, interfere with, or prejudice the our subrogation or reimbursement rights. You (or your legal representative) must cooperate with us (or a company that we have contracted with to recover subrogation claims) by signing documents and doing whatever is necessary for CareSource to exercise its reimbursement, assignment, and subrogation rights. If you do not, we will have the legal right to recover our payments and costs (including attorneys' fees) by formal action against you for the reimbursement of money owed to CareSource.

CareSource's subrogation and reimbursement rights are a first priority lien on any recovery, which means that they are paid before any of your other claims are paid. We are entitled to recover up to the full amount of Benefits we have paid, without regard to whether you (or your legal representative) have been made whole or received full compensation for damages and without regard to any legal fees expended or costs that you (or your legal representative) has paid or are owed.

However, notwithstanding the above, the Plan's rights against a Third Party or you in a Tort Action will be subject to the following conditions:

- If less than the full value of the Tort Action is recovered for comparative negligence, diminishment due to a party's liability under sections 2307.22 to 2307.28 of the Ohio

Revised Code, or by reason of the collectability of the full value of the claim for Injury, death, or loss to person resulting from limited liability insurance or any other cause, the Plan's or other person's or entity's claim shall be diminished in the same proportion as the your interest is diminished.

- If a dispute regarding the distribution of the recovery in the Tort Action arises, either the Plan or you may file an action under Chapter 2721 of the Ohio Revised Code to resolve the issue of the distribution of the recovery.

Our right of recovery shall not be reduced due to the "Double Recovery Rule", "Made Whole Rule", "Common Fund Rule" or any other legal equitable doctrine. Our subrogation rights are enforceable against all forms of recovery regardless of whether the settlement proceeds are designated as payment for medical expenses or otherwise, and you must repay to us the Benefits paid on your behalf from another Third Party from any settlement proceeds.

SECTION 11 – WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end;
- Extended coverage; and
- How to continue coverage after it ends.

Guaranteed Renewable

You may renew this Plan at your option without regard to your health condition. The Marketplace and/or CareSource, as the case may be, can terminate your coverage for the reasons below:

- You are no longer eligible for coverage under the Plan through the Marketplace.
- You do not pay your Premium on time provided that the applicable grace period set forth in Section 2: *How the Plan Works* has been exhausted.
- You commit an act, practice of omission that constitutes Fraud.
- You commit an intentional misrepresentation of material fact.
- You change coverage to another Qualified Health Plan during an open or special enrollment period.
- CareSource terminates or is decertified by the Marketplace.
- You obtain other minimum essential coverage.
- You no longer reside in our Service Area.

If you enrolled in the Plan through the Marketplace, then you may terminate coverage under this Plan by providing at least fourteen (14) calendar days prior notice to the Marketplace. To request termination through the Marketplace, you can login to your Marketplace account (healthcare.gov/login) or contact the Marketplace at 1-800-318-2596. The termination effective date may be effective as soon as 14 days from the date that you request termination, unless otherwise agreed upon. Retroactive termination requests will be processed in accordance with 45 C.F.R. § 155.430.

If you did not enroll in the Plan through the Marketplace, then you may terminate coverage under this Plan by providing at least fourteen (14) calendar days prior notice to us. Please call Member Services to request termination. Such termination shall be effective fourteen (14) calendar days after we receive your request for termination, unless otherwise agreed upon.

If we discontinue offering a particular type of Plan, you will be notified at least ninety (90) days before the date of discontinuation and you will be given the opportunity to purchase another Plan currently being offered by us.

Notice of Termination and Date of Termination

The Marketplace and Plan will notify you if your coverage ends at least thirty (30) calendar days prior to the last day of coverage, with such effective date determined by the Marketplace in accordance with 45 C.F.R. §155.430(d) when applicable. Where the coverage end is retroactive or less than 30 days from the date we are made aware, we will notify you within thirty (30) calendar days of us being made aware. The notice will set forth the reason for the termination and will tell you the date your coverage under the Plan ends. If you are delinquent on premium payment, we will provide you with notice of such payment delinquency. If your coverage is cancelled, we will return to you any unearned portion of premiums you paid beyond the month in which the cancellation is effective.

Notice to you shall be deemed notice to your enrolled Dependents and is sufficient if mailed to your address as it appears in our records. Notice is effective when deposited in the United States mail, with first class postage prepaid.

Reinstatement

If you enrolled in the Plan through the Marketplace and your Benefits were terminated because you did not pay your Premium in full by the end of your Grace Period, you will not be able to reinstate your Benefits. However, we recommend that you contact the Marketplace to see what options are available to you.

If you did not enroll in the Plan through the Marketplace and if any renewal Premium is not paid within the time granted the Covered Person for payment, a subsequent acceptance of Premium by us or by any agent duly authorized by us to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate Benefits under the Plan: provided, however, that if CareSource or such agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, Benefits under the Plan will be reinstated upon approval of such application by us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless we have previously notified the Covered Person in writing of its disapproval of such application. The reinstated Plan shall cover only loss resulting from such accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after such date. In all other respects, the Covered Person and CareSource shall have the same rights thereunder as they had under the Plan immediately before the due date of the defaulted Premium, subject to any provisions indorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Benefits after Termination

We will not pay for services, supplies, or drugs you receive after your coverage ends, even if you had a medical condition (known or unknown), including Pregnancy, that requires medical care after your coverage ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are receiving medical treatment on that date, except as specifically provided below.

In the event that we terminate your coverage while you are receiving Inpatient care in a Hospital, we will continue your coverage until the earliest occurrence of any of the following: (1) your discharge from the Hospital; (2) the determination by your Physician that Inpatient care in the Hospital is no longer Medically Necessary for you; (3) your reaching the limit for contractual Benefits; or (4) the effective date of any new coverage you have; or (5) sixty (60) days after your coverage is terminated; provided, however, that we will not continue your coverage for Inpatient care if your coverage terminates (a) because you terminate coverage under this Section 11, or (b) if you fail to pay Premium within the applicable Grace Period set forth in Section 2: *How the Plan Works*; or (c) CareSource's insolvency or end of operations, provided, however, if you are receiving Inpatient Services at a Network Hospital, your coverage for such Inpatient Services will be continued for up to thirty (30) calendar days after our insolvency or end of operations.

When your coverage ends, CareSource will still pay Claims for Covered Services that you received before your coverage ended. Except as set forth above, Benefits are not provided for Health Care Services, supplies, and pharmaceutical products that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Note: CareSource has the right to require you to pay back Benefits we paid to you or paid in your name during the time you were wrongly covered under the Plan.

Rescission

Under certain circumstances, we may take away your coverage under the Plan. A Rescission of your coverage means that the coverage may be legally voided retroactive to the day we began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes Fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a Rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review. See Section 8: *Complaint Process, Claims Procedures, and Adverse Benefit Determination Appeals* for more information.

Certification of Prior Creditable Coverage

If your coverage is terminated and we are required by law to give you evidence of coverage, you will receive a certification showing when you were covered under the Plan. If you have any questions, please contact Member Services.

SECTION 12 – OTHER IMPORTANT INFORMATION

What this section includes:

- Your relationship with CareSource;
- Relationships with Providers; and
- Other important information you need to know.

No Waiting Periods or Pre-Existing Conditions

There are no waiting periods or pre-existing condition limits that apply to Benefits covered by the Plan.

No Lifetime Limits on the Dollar Value of Essential Health Benefits

The Plan does not impose any lifetime limits on the dollar amount of Essential Health Benefits, as defined in Section 13: *Glossary*, covered under this Plan.

No Annual Limits on the Dollar Value of Essential Health Benefits

The Plan does not impose any annual limits on the dollar amount of Essential Health Benefits, as defined in Section 13: *Glossary*, covered under this Plan.

Your Relationship with CareSource

CareSource does not provide Health Care Services or make treatment decisions. This means:

- CareSource does not recommend what Health Care Services you need or will receive. You and your Physician make those decisions.
- CareSource communicates to you decisions about whether we will cover or pay for the Health Care Services that you may receive.
- CareSource does determine, according to our policies and nationally recognized guidelines, what Medically Necessary Covered Services are eligible Benefits under this Plan.
- We may not pay for all Health Care Services you or your Physician may believe are necessary.

CareSource's Relationship with Providers

The relationships between CareSource and Network Providers are contractual relationships between independent contractors. Network Providers are neither CareSource's agents nor employees. CareSource and any of its employees are neither agents nor employees of Network Providers. CareSource does not provide Health Care Services or supplies, nor does CareSource practice medicine. Instead, CareSource arranges for Providers to participate in a Network. CareSource also pays Benefits. Network Providers are independent practitioners who run their own offices and Facilities. CareSource does not select Network Providers based on quality

measures, member experience measures, patient safety or cost-related measures. CareSource's credentialing process confirms public information about the Providers' licenses and other credentials, but does not assure the quality of the Health Care Services provided. Providers are not CareSource's employees. CareSource does not have any other relationship with Network Providers such as principal-agent or joint venture. CareSource is not liable for any act or omission of any Provider.

Your Relationship with Providers

The relationship between you and any Provider is that of Provider and patient. Your Provider is responsible for the quality of the Health Care Services provided to you. You:

- are responsible for choosing your own Providers;
- are responsible for paying, directly to your Provider, any amount identified as a Covered Person responsibility, including Copayments, Coinsurance, any Annual Deductible and any amounts that are more than Eligible Expenses;
- are responsible for paying, directly to your Provider, the cost of any Non-Covered Service; and
- are responsible for deciding with your Provider what care you should and should not receive.

If CareSource determines that you are using Health Care Services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Services. If you do not make a selection within thirty (30) calendar days of the date you are notified, we will pick a Network Physician for you. If you do not use the Network Physician to coordinate all of your care, any Covered Services you receive will not be paid.

Reimbursements for Services of Osteopath, Optometrist, Chiropractor, Podiatrist, Psychologist, or Dentist

When this Plan provides Benefits for Covered Services that may be legally performed in Ohio for the practice of medicine, osteopath, optometry, chiropractic, podiatry, psychology, social work or dentistry, such Benefits will not be denied when such Covered Service is rendered by a Network Provider licensed in the State of Ohio as a physician, osteopath, optometrist, chiropractor, podiatrist, licensed clinical social worker, doctorate of psychology or other individual legally qualified to practice psychology, or dentist, as the case may be.

Interpretation of Benefits

CareSource has the sole and exclusive discretion to:

- Interpret Benefits under the Plan;
- Interpret the other terms, conditions, limitations and Exclusions of the Plan, including this EOC and any Riders/Enhancements and/or Amendments; and
- Make factual determinations related to the Plan and its Benefits.

CareSource may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan. In certain circumstances, for purposes of overall cost savings or efficiency, CareSource may, in its discretion, offer Benefits for services that would otherwise not be Covered Services. The fact that CareSource does so in any particular case will not in any way be deemed to require CareSource to do so in other similar cases.

Guaranteed Availability and Renewability

We are not obligated to renew or continue Benefits if you fail to pay Premiums; if you perform an act or practice that constitutes Fraud or the making of an intentional misrepresentation; if CareSource ceases to offer the Plan; if you move outside the Service Area, or become otherwise ineligible for Benefits.

Claims

Your Provider is responsible for requesting payment from us. If your Provider is unable to submit Claims for payment to us in accordance with Plan's customary practices, you may submit a Claim directly to us by using the member Claim form that can be found at www.CareSource.com/marketplace or by calling Member Services.

Notice of Claim

Written notice of a Claim must be given to us within sixty (60) days after the occurrence or commencement of any loss covered by the Plan, or as soon as thereafter as is reasonably possible. Notice given by you or an Authorized Representative to CareSource at Attn: Claims Department, P.O. Box 804, Dayton, Ohio 45401, or to any authorized agent of CareSource, with information sufficient to identify the insured, shall be deemed notice to us.

Claim Forms

Upon receipt of notice of Claim, we will furnish you with the appropriate forms to file proof of loss. The form will be sent to you within fifteen (15) days after the receipt of such notice. If you do not receive the forms within fifteen (15) days, You shall be deemed to have complied with the requirements of this EOC as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss satisfactory to us must be submitted to us within ninety (90) days after the date of the event for which Claim is made or as soon as reasonably possible. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Many Providers may file Claims for you. If your Provider will not file a Claim, and you do not receive a Claim form from us within fifteen (15) days of our receipt of notice of Claim, you may

submit a written notice of services rendered to us without the Claim form. The same information that would be given on the Claim form must be included in the written proof of loss. This includes the name of the Covered Person, relationship to you, identification number, date, type and place of service, your signature and the Provider's signature be fully discharged from that portion of its liability. Proof of Loss shall be submitted to us at: P.O. Box 630568, Cincinnati, Ohio 45263-0568.

Payment of Benefits

We will pay or deny a Claim within thirty (30) calendar days after we receive a Claim that includes all of the information necessary to process the Claim. If additional supporting information is required to process the Claim, we will notify the applicable person(s) within fifteen (15) calendar days after receipt of the Claim. This notice will detail the supporting documentation needed. The timeframe for processing this Claim is then extended to forty-five (45) calendar days. The days that elapse between the notification and receipt of the requested documentation are not counted as a part of the forty-five (45) day calendar period. You and your Provider will be notified when a Claim is denied. The notification will include the reason(s) for the denial.

Explanation of Benefits

After you receive Health Care Services, you will generally receive a written explanation of benefits summarizing the Benefits you receive. This explanation of benefits is not a bill for Heath Care Services.

Legal Action

You may not bring any suit on a Claim until at least sixty (60) days after the required Claim document is given. You may not bring any suit more than three (3) years after the date of submission of a proof of loss. Any claim must be brought in Montgomery County, Ohio.

Information and Records

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided Health Care Services to you to furnish CareSource with all information or copies of records relating to the Health Care Services provided to you. CareSource has the right to request this information at any reasonable time. CareSource may request additional information from you to decide your Claim for Benefits. Such information and records will be considered confidential.

Incentives to Providers

Network Providers may be provided financial incentives by CareSource to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality measures, Covered Person satisfaction, and/or cost-effectiveness; or

- A practice called capitation, which is when a group of Network Providers receives a monthly payment from CareSource for each Covered Person who selects a Network Provider within the group to perform or coordinate certain Health Care Services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives, you may contact us. You can ask whether your Network Provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network Provider.

Incentives to You

Sometimes you may be offered coupons or other 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, but CareSource recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID Card if you have any questions.

Rebates and Other Payments

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

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not 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 delivery by cesarean section; however, the issuer may pay for a shorter stay if the attending Provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, an issuer may not, under federal law, require that a Physician or other Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours); however, to use certain providers of Facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, please contact Member Services.

Women's Health and Cancer Rights Act Notice

Effective October 21, 1998, the Federal Women's Health and Cancer Rights Act requires all health insurance plans that provide coverage for a mastectomy must also provide coverage for the following medical care:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Covered Services are subject to all provisions described in the Plan, including but not limited to Annual Deductible, Copayment, rate of payment, Exclusions, and limitations.

Physical Examination and Autopsy

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Provider of our choice examine you at our expense when and as often as reasonably required while the Claim is pending, and to make an autopsy in case of death where it is not forbidden by law.

Genetic Screening

When processing any application you submit to us related to coverage under the Plan, we will not:

- Require you to submit to genetic screening or testing;
- Take into consideration the results of genetic screening or testing;
- Make any inquiry to determine the results of genetic screening or testing; or
- Make a decision adverse to you based on entries in your medical record or other reports related to genetic screening or testing.

Legal Contract

This EOC, any Riders/Enhancements, Attachments, including the Schedule of Benefits, Amendments, and documentation submitted to the Marketplace and CareSource, constitute the entire legal contract between you and CareSource, and as of the effective date of your coverage, supersede all other agreements between us. This EOC, its Riders/Enhancements, and Amendments constitute the legal contract between CareSource and you. Your payment of the first Premium owed to us and your receipt of Benefits under the Plan indicate your acceptance of and agreement with the terms and conditions of this EOC, its Riders/Enhancements, and Amendments. Any and all statements that you have made to us and any and all statements that we have made to you are representations and not warranties. No such statement, unless it is contained in this EOC and any of its Riders/Enhancements or Amendments, will be used in defense to a Claim under this EOC, its Riders/Enhancements, or Amendments.

Medicare

Any Health Care Services covered under both this Plan and Medicare will be paid according to Medicare secondary payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines. As a Medicare secondary payor, benefits under this Plan shall be determined after those of Medicare. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare, we will calculate benefits as if they had enrolled.

The benefits under this Plan for Covered Persons age 65 and older or Covered Persons otherwise eligible for Medicare, except those Covered Persons with chronic kidney disease or End Stage Renal Disease ("ESRD"), do not duplicate any benefit for which Covered Persons are entitled under Medicare, except when federal law requires us to be the primary payor. Where Medicare is the primary payor, all sums payable by Medicare for Health Care Services provided to Covered Persons shall be reimbursed by or on behalf of the Covered Persons to us to the extent we have made payment for such Health Care Services.

This Plan is not a Medicare supplemental policy. If you are eligible for Medicare, please review the "Guide to Health Insurance for People with Medicare" available from CareSource or at https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap-guide.pdf.

Limitation of Action

No legal proceeding or action may be brought more than three (3) years from the date the cause of action first arose. Damages shall be limited to recovery of actual Benefits due under the terms of this EOC. The Covered Person waives any right to recover any additional amounts or damages, including, but not limited to, punitive and/or exemplary damages.

Changes/Amendments

This EOC may be amended. In the event that we make a material modification to this EOC other than during the renewal or reissuance of coverage, we will provide notice of the material modification to you no later than sixty (60) calendar days prior to the date on which the material modification will become effective.

Misstatement of Information

If you misstate information you submit to the Marketplace or Plan, including but not limited to information about your age, state of residence, citizenship, family, or income, we will adjust the Premium(s) under the Plan to the amount the Premium(s) would have been if such information had been correctly stated.

Non-Discrimination

CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race,

disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please contact CareSource at 1-800-479-9502 TTY: 711.

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
1-844-539-1732, TTY: 711
Fax: 1-844-417-6254
CivilRightsCoordinator@CareSource.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

Conformity with Law

This Plan shall be construed under the laws of the State of Ohio. Any provision of this Plan which is in conflict with the laws of Ohio when this EOC was issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Severability

In the event that any provision of this EOC is declared legally invalid by a court of law, such provision will be severable and all other provisions of the EOC will remain in full force and effect.

Waiver and Oral Statements

No agent or other person, except as authorized officer of CareSource, has authority to waive any conditions or restrictions of this EOC, to extend the time for paying Premium, or to bind us by making any promise or representation or by giving or receiving information. No oral statement of any person shall modify or otherwise affect the Benefits, limitations, or Exclusions of this EOC or convey or void any coverage under the Plan.

Any failure of CareSource to enforce any term or condition of this EOC shall not constitute a waiver in the future of any term or condition of this EOC. We may choose not to enforce any term or condition of the Plan. Such choice shall not constitute a waiver in the future of any such term or condition.

Non-Assignment

The Benefits provided under this Plan are for your personal benefit. You may not assign or transfer to any third party any of your rights to Benefits or Covered Services under this Plan. Any attempt by you to assign this Plan to any third party is void.

Clerical Errors

If a clerical error or other mistake occurs, that error will not deprive you of Benefits under this Plan, nor will it create a right to Benefits.

Circumstances Beyond Our Control

If circumstances arise that are beyond the control of CareSource, we will make a good-faith effort to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within our control, include but are not limited to:

- A major disaster or epidemic,
- An act of God,
- A nuclear explosion or accident,
- Complete or partial destruction of Facilities,
- A riot,
- Civil insurrection,
- Labor disputes that are out of the control of CareSource,
- Disability affecting a significant number of a Network Provider's staff or similar causes, or
- Health Care Services provided under this EOC are delayed or considered impractical.

Under such circumstances, CareSource and Network Providers will provide the Health Care Services covered by this EOC as far as is practical under the circumstances and according to their best judgment; however, we and our Network Providers will accept no liability or obligation for

delay, or failure to provide or arrange Health Care Services if the failure or delay is caused by events or circumstances beyond our control.

Express Consent to be Contacted

By providing your contact information to the Marketplace and/or CareSource during the application and enrollment process and at any other time you expressly consent and agree that CareSource and its affiliates, agents and service providers may contact you by, including but not limited to, manual calling methods, prerecorded or artificial voice messages, text messages, written correspondence, emails and/or automatic telephone dialing systems. You agree that CareSource and its affiliates, agents and service providers may use any email address and/or any telephone number, including a number for a cellular phone or other wireless device, you provide now or in the future to the Marketplace and/or CareSource and its affiliates, agents and service providers to contact you.

Fraud Notice

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a Claim containing false or deceptive statement is guilty of insurance fraud.

Time Limit on Certain Defenses

After three (3) years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a Claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the three (3) year period.

After the policy has been in force for a period of three (3) years during the lifetime of the Member (excluding any period during which the Member is disabled), it shall become incontestable as to the statements contained in the application.

For purposes of any reinstatement of this Policy, we may contest coverage under the Policy on account of the applicant's fraud or material misrepresentation only if fraud or material misrepresentation was contained in the reinstatement application, and then only for the period during which the Policy was reinstated.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding the CareSource's standards for the collection, use, and disclosure of information gathered in connection with our business activities.

- We may collect personal information about a Covered Person from persons or entities other than the Covered Person.

- We may disclose Covered Person information to persons or entities outside of CareSource without Covered Person authorization in certain circumstances.

- A Covered Person has a right of access and correction with respect to all personal information collected by us.

- A more detailed notice will be furnished to you upon request.

SECTION 13 – GLOSSARY

What this section includes:

- Definitions of terms used throughout this EOC

Active Course of Treatment means any of the following:

(1) An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted;

(2) An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the Covered Person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;

(3) The second or third trimester of pregnancy, through the postpartum period; or

(4) An ongoing course of treatment for a health condition for which a treating Provider attests that discontinuing care by the Provider would worsen the condition or interfere with anticipated outcomes.

Adult means a person who is at least nineteen (19) years old.

Adverse Benefit Determination means a decision by CareSource to deny, reduce, or terminate a requested Health Care Service or Benefit in whole or in part, including all of the following:

- A determination that the Health Care Service does not meet our requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational Services;
- A determination of your eligibility for Benefits under the Plan;
- A determination that a Health Care Service is not a Covered Service;
- The imposition of an Exclusion or other limitation on Benefits that would otherwise be covered;
- A determination not to issue you coverage, if applicable to this Plan; or
- A determination to rescind coverage under the Plan.

Alternate Facility means a freestanding health care facility that is not a Hospital or a Facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. An Alternate Facility provides one or more of the following Health Care Services on an Outpatient basis, as permitted by law: pre-scheduled surgical services, Emergency Health Care Services, Urgent Care Services, pre-scheduled rehabilitative, laboratory, or Diagnostic Services. An Alternate Facility may also provide Behavioral Health Care Services on an Outpatient, intermediate or Inpatient basis.

Ambulance means a licensed ambulance service that is designed, equipped, and used only to transport a Covered Person with a Sickness or Injury, provided it is staffed by Emergency medical technicians, paramedics, or other certified first responders. An Ambulance may transport a Covered Person by ground, water, fixed wing air, or rotary wing air transportation. An ambulette service is not an Ambulance regardless of whether it meets certain criteria set forth above.

Ambulance Services means transportation by an Ambulance of a Covered Person who has a Sickness or Injury.

Amendment means any written changes or additions to this EOC. Amendments are subject to all conditions, limitations, and Exclusions of the Plan, except for those that are changed by the Amendment. CareSource at all times reserves the right to make Amendments.

Annual Deductible or Deductible means the amount you must pay for Covered Services in a Benefit Year before we will begin paying for Benefits in that Benefit Year. Copayments do not count towards the Annual Deductible. Network Benefits for Preventive Health Care Services are never subject to payment of the Annual Deductible.

Annual Out-of-Pocket Maximum means the maximum amount you pay in a Benefit Year relating to obtaining Benefits. When you reach the Annual Out-of-Pocket Maximum, Benefits for Covered Services that apply to the Annual Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of the Benefit Year. Payments toward the Annual Deductible, Copayments and Coinsurance for Covered Services will apply to your Annual Out-of-Pocket Maximum, unless otherwise noted below.

The following costs will never apply to the Annual Out-of-Pocket Maximum:

- Any charges for services that are not Covered Services;
- Coinsurance amounts for Covered Services available by an optional Rider/Enhancement, unless specifically stated otherwise in the Rider/Enhancement; and
- Copayments for optional adult dental and vision benefits or any other optional Rider/Enhancement.

Even when the Annual Out-of-Pocket Maximum has been reached, you will still be required to pay:

- Any charges for Non-Covered Services;
- Charges that exceed Eligible Expenses;
- Copayments and Coinsurance amounts for Covered Services available by an optional Rider/Enhancement, unless specifically stated otherwise in the Rider/Enhancement; and
- The amount of any reduced Benefits if you do not obtain authorization from us when required to do so under the terms of the Plan.

Applied Behavioral Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce significant improvement in

human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Authorized Representative means an individual who represents a Covered Person in an internal appeal or external review process of an Adverse Benefit Determination and who is any one of the following:

- A person to whom you have given express, written consent to represent you in an internal appeals process or external review process of an Adverse Benefit Determination;
- A person authorized by law to provide substituted consent for you;
- A family member or a treating health care professional when, and only when, you are unable to provide consent.

Autism Spectrum Disorder means any of the following pervasive developmental disorders as defined by the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association): Autism; Asperger's Disorder; or other condition that is specifically categorized as a pervasive developmental disorder in the *Manual*.

Basic Health Care Services includes the following Health Care Services when medically necessary: (i) physician's services, except when such services are supplemental, (ii) Inpatient hospital services, (iii) outpatient medical services, (iv) emergency health care services, (v) urgent care services, (vi) diagnostic laboratory services and diagnostic and therapeutic radiologic services, (vii) diagnostic treatment services, other than prescription drug services, for biologically based mental illnesses, (viii) preventive health care services, including but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care, and (ix) routine patient care for patients enrolled in an eligible cancer clinical trial.

Behavioral Health Disorder means those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association).

Behavioral Health Care Services means Health Care Services for the diagnosis and treatment of Behavioral Health Disorders, alcoholism and Substance Use Disorders that are listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association), unless those services are specifically excluded. The fact that a condition or disorder is listed in the current *Manual* does not mean that treatment for the condition is a Covered Service.

Benefits or Benefit means your right to payment for Covered Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations, and Exclusions of the Plan, including this EOC and any attached Riders/Enhancements and Amendments.

Benefit Year means the calendar year for which you have coverage under the Plan.

Brand-name Drug means a Prescription Drug that is either manufactured and marketed under a trademark or name by a specific drug manufacturer or identified by CareSource as a Brand-name

Drug based on available data resources (including, but not limited to, First DataBank) that classify drugs as either Brand-name or Generic based on a number of factors. Products identified as "brand name" by the manufacturer, Pharmacy, or your Physician may not be classified as Brand-name Drug by the PIP.

Business Day means Monday through Friday, excluding any state or federal holiday observed by CareSource.

Business Hours means Monday through Friday, 8 a.m. EST to 5 p.m. EST, excluding any state or federal holiday observed by CareSource.

CareSource24® means CareSource's nurse help line, for non-Emergency health situations, which Covered Persons can call 24 hours a day, seven days a week, including holidays. The call is free and confidential. Covered Persons speak directly with a registered nurse about their symptoms or health questions. The nurse will quickly assess your situation and help you choose the most appropriate action. A fax will then be sent to the CareSource Covered Person's PCP to help him or her coordinate better care for the CareSource Covered Person.

Chiropractor means any doctor of chiropractic who is duly licensed and qualified to provide chiropractic services.

Chronic Condition means a medical condition that has persisted after reasonable efforts have been made to relieve or cure its cause and has continued, either continuously or episodically, for longer than six (6) continuous months.

Chronic Pain means pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued, either continuously or episodically, for longer than three continuous months. Chronic Pain does not include pain associated with a Terminal Condition or with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a Terminal Condition.

Claim means a request for a Benefit (including reimbursement of an Eligible Expense) made to us by your Provider or you.

Coinsurance means the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Services after the Annual Deductible is satisfied and until you reach your Out-of-Pocket Maximum. (*see* Section 2).

Congenital Anomaly means a physical developmental defect that is present at birth and is identified within the first 12 months of birth.

Copayment means the charge, stated as a flat dollar amount, that you are required to pay for certain Covered Services (*see* Section 2).

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

Covered in Full means that the covered service is provided to the member at no cost to you if provided by a Network Provider and provisions contained within this Evidence of Coverage are adhered to.

Covered Person means an individual, including you or your Dependent, who is properly enrolled by the Marketplace and/or Caresource, as the case may be, and due to such enrollment is entitled to receive Benefits provided under this Plan. Often, a Covered Person is referred to as "you."

Covered Services means those Health Care Services that are (1) covered by a specific Benefit provision of the Plan; (2) not Excluded under the Plan; and (3) determined to be Medically Necessary per our medical policies and nationally recognized guidelines and that we determine to be all of the following: Provided for the purpose of preventing, diagnosing, or treating a Sickness, Injury, Behavioral Health Disorder, Substance Use Disorder, or their symptoms; consistent with nationally recognized scientific evidence, as available, and prevailing medical standards and clinical guidelines, as described below; and not provided for the convenience of you, a Provider, or any other person. In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings: "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community. "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

Custodial Care means care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for a Sickness or Injury. Custodial Care is care that cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Custodial Care includes, but is not limited to: assistance with walking, bathing, or dressing; transfer or positioning in bed; normally self-administered medicine; meal preparation; feeding by utensil, tube, or gastrostomy; oral hygiene; ordinary skin and nail care; catheter care; suctioning; using the toilet; enemas; and preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel. Custodial Care includes maintenance care provided by a Covered Person's family, friends, health aides, or other unlicensed individuals after an acute medical event when such Covered Person has reached the maximum level of physical or mental function. In determining whether an individual is receiving Custodial Care, the factors considered are the level of care and medical supervision required and furnished.

Day Hospital means a Facility that provides day rehabilitation services on an Outpatient basis.

Dependent means a person who meets the requisite criteria listed in Section 1: *Eligibility Requirements*.

Designated Pharmacy means a Pharmacy that has entered into an agreement with CareSource or with an organization contracting on its behalf, to provide specific Prescription Drugs. The fact that a Pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Diagnostic Services means Health Care Services performed on a Covered Person who is displaying specific symptoms in order to detect or monitor a disease or condition. A Diagnostic Service also includes a Medically Necessary Preventive Health Care Services screening test that may be required for a Covered Person who is not displaying any symptoms, if, and only if, it is ordered by a Provider.

Domiciliary Care means care provided in a residential institution, treatment center, halfway house, or school because a Covered Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Durable Medical Equipment means medical equipment that 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 of use to a person only in the presence of a disease or physical disability, is appropriate for use in the home, and is not implantable within the body.

Effectuated or Effectuation means paying your Premium and/or enrolling in the Plan in accordance with Marketplace standards, state law, or Plan guidelines/rules, as applicable, in order to allow the Benefits, terms, conditions, limitations, and Exclusions under this Evidence of Coverage to take effect.

Eligible Expenses means the amount we will pay for Covered Services, incurred while the Plan is in effect, determined as stated below:

> Eligible Expenses are our contracted fee(s) with our Network Providers for Covered Services. When Covered Services are received from Non-Network Providers as a result of an emergent/urgent condition or as otherwise arranged by your PCP or other Network Physician and approved by us, Eligible Expenses are the Maximum Allowable Amount, unless a different amount is negotiated.
>
> Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines following evaluation and validation of all Provider billings 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; as reported by generally recognized professionals or publications; as used for Medicare; or as determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Individual means an applicant for an individual policy who has eighteen (18) months prior creditable coverage, with no break in coverage of more than sixty-three (63) days, the most recent of which was an employment related group plan sponsored by an employer, church or governmental plan. Certain children are Eligible Individuals, even if they do not have a full 18 months of creditable coverage, provided that they were covered under creditable coverage within thirty (30) days of birth, adoption, or placement for adoption and have not had a sixty-three (63) day break in coverage.

Emergency Medical Condition or Emergency means a medical condition that manifests itself by signs and symptoms of sufficient severity or acuity, including severe pain, such that a prudent

layperson with an average knowledge of health and medicine could reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
(2) serious impairment to bodily functions, or
(3) serious dysfunction of any bodily organ or part; or

Examples of Emergencies include, but are not limited to, a heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures, and convulsions.

Emergency Health Care Services means Health Care Services necessary for the treatment of an Emergency, including (i) a medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition, or (ii) such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

Emergency Room means the section, department or facility of a Hospital that either: (1) is licensed by the state as an emergency room; (2) held out to the public as providing treatment for Emergency Medical Conditions; or (3) on one-third of the visits to the department in the preceding calendar year actually provided treatment for Emergency Medical Conditions on an urgent basis.

Essential Health Benefits means ambulatory patient services, Emergency Health Care Services, Inpatient Services, Maternity and newborn care, mental health and Substance Use Disorders Treatment, including Behavioral Health Care Services, Prescription Drugs, rehabilitative and Habilitative services and devices, Laboratory services, Preventive and wellness Health Care Services, chronic disease management, and pediatric services, including oral and vision care as further defined in 42 U.S.C § 18022 and state law.

Exclusions, Exclusion or Excluded means Health Care Services that are not Covered Services under the terms of the Plan.

Experimental or Investigational Services or **Experimental or Investigational** means medical, surgical, diagnostic, psychiatric, Substance Use Disorders Treatment or other Health Care Services, technologies, supplies, treatments, procedures, drug therapies 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 by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; subject to review and approval by any institutional review board for the proposed use; the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight (this includes diagnostic testing for purposes of possible inclusion in a clinical trial); or any service billed with

a temporary procedure code. Devices that are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational. If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may determine that an Experimental or Investigational Service meets the definition of a Covered Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but an Unproven Service, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Facility means an appropriately licensed Hospital; nursing home; county home or a county nursing home; a freestanding dialysis center; a freestanding Inpatient Rehabilitation Facility; an ambulatory surgical facility; a freestanding cardiac catheterization facility; a freestanding birthing center; a freestanding or mobile diagnostic imaging center; a freestanding radiation therapy center. A health care facility does not include the offices of private Physicians and dentists whether for individual or group practice, an institution for the sick that is operated exclusively for patients who use spiritual means for healing and for whom the acceptance of medical care is inconsistent with their religious beliefs, accredited by a national accrediting organization, exempt from federal income taxation under section 501 of the Internal Revenue Code of 1986, 100 Stat. 2085, 26 U.S.C.A. 1, as amended.

Family Planning Services mean educational, comprehensive medical or social activities which enable individuals, including minors, to select the means by which they can anticipate and attain their desired number of children, the spacing and timing of their births.

Fraud means intentionally, or knowingly and willfully, attempting to execute or participate in a scheme or action to falsely obtain unfair or unlawful financial or personal gain from any health care benefit program. Fraud may include, but is not limited to: seeking reimbursement for services not rendered; selling Prescription Drugs that were prescribed to you to someone else; misrepresenting the date a service was provided; misrepresentation of services (*e.g.*, misrepresenting who rendered the service, the condition or diagnosis of the patient, the charges involved, or the identity of the Provider or recipient); seeking reimbursement for excessive, inappropriate, or unnecessary testing or other services; receiving kickbacks for making a referral or for receiving services related to the referral; altering Claim forms, electronic records, or medical documentation; improper use of your Member ID Card; or providing false information or withholding accurate information relating to eligibility for coverage under this Plan.

Generic Drug means a Prescription Drug that is either:

- Chemically equivalent to a Brand-name Drug; or
- Identified by CareSource as a Generic Drug based on available data resources, including, but not limited to, First DataBank, that classify drugs as either brand-name or generic based on a number of factors. Products identified as a "generic" by the manufacturer, Pharmacy or your Physician may not be classified as a Generic Drug by the PIP.

Grace Period means the time period set forth in Section 2: *How the Plan Works*.

Grievance means a written complaint submitted by or on behalf of a Covered Person.

Habilitative Services or Habilitative means those Health Care Services that help a person keep, learn or improve skills and functioning for daily living. Examples of Habilitative Services include therapy for a child who is not walking or talking at the expected age. These Habilitative Services may include physical and occupational therapy, speech-language pathology, and other Health Care Services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

Health Care Services means services, supplies, devices, or pharmaceutical products for the diagnosis, prevention, treatment, cure, or relief of health condition, Sickness, Injury, or disease.

Home Health Care Agency means a program or organization authorized by law to provide Health Care Services in the home.

Home Health Care Services means any form of care given within the home. This home care can range from care provided by a home health aide, home health nurse, companion, or caregiver and includes intermittent care, respite care, and home therapies. The term home care covers both medical and non-medical forms of care.

Hospice Care Program means coordinated program of home, Outpatient, and Inpatient care and services that is operated by a person or public agency and that provides care and services to Hospice Patients, including services to Hospice Patients' families, through a medically directed interdisciplinary team, under interdisciplinary plans of care established pursuant to section 3712.06 of the Ohio Revised Code, in order to meet the physical, psychological, social, spiritual, and other special needs that are experienced during the final stages of illness, dying, and bereavement. Hospice Care Program does not include a pediatric respite care program.

Hospice Patient means a patient, other than a pediatric respite care patient, who has been diagnosed with a Terminal Illness, has an anticipated life expectancy of six months or less, and has voluntarily requested and is receiving care from a person or public agency licensed under Ohio law to provide a Hospice Care Program.

Hospital means an institution, operated as required by law, that is all of the following: is primarily engaged in providing Health Care Services, on an Inpatient basis, for the acute care and treatment of injured or sick individuals; care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; has 24-hour nursing services. A Hospital does not include a place devoted primarily to rest, Custodial Care, or care of the aged and is not a nursing home, convalescent home, or similar institution.

HRA means a health reimbursement arrangement funded solely by employer contributions that reimburses an employee's medical care expenses up to a maximum dollar amount for a coverage period.

HSA Eligible Plan means the plan meets the state, federal, and IRS requirements to be considered a high deductible health plan allowing the Member to leverage the benefits of a health savings account. CareSource plans with the term "HSA Eligible" in the plan name meet this definition.

ID Card means the CareSource Identification Card that you will receive when you are enrolled under the Plan.

Individual Coverage HRA means a health reimbursement arrangement which requires employees and any covered dependents to be enrolled in individual health insurance coverage in order to be covered by and receive reimbursements for medical care expenses from the HRA, which may include premiums and cost sharing for individual health insurance coverage.

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

Inpatient means relating to a patient who has been admitted to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility.

Inpatient Services means Health Care Services relating to a patient admitted to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility.

Inpatient Rehabilitation Facility means a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation Health Care Services (*e.g.*, physical therapy, occupational therapy and/or speech therapy) on an Inpatient basis, as authorized by law.

Inpatient Stay means an uninterrupted confinement following formal admission to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility.

Insurer means any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation or ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

Marketplace means the health insurance benefit exchange established by the Affordable Care Act for the State of Ohio.

Maternity Services means Health Care Services provided in relation to Pregnancy and delivery of a newborn child. Maternity Services include care during labor, birthing, prenatal care, and postpartum care.

Maximum Allowable Amount means the maximum amount that the Plan will allow and provide Benefits for Covered Services you receive.

Medically Necessary/Medical Necessity means Health Care Services that are determined to be medically appropriate in accordance with CareSource's medical policies and nationally recognized guidelines; are not Experimental or Investigational Services; are necessary to meet the basic health needs of the Covered Person; are rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service; are consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by us; are consistent with the

diagnosis of the condition; are required for reasons other than the convenience of the Covered Person or his/her Physician; and are demonstrated through prevailing peer-reviewed medical literature to be either: (a) safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed or (b) safe with promising efficacy for treating a life-threatening Sickness or condition in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For purposes of this definition, the term "life threatening" is used to describe Sickness or conditions that are more likely than not to cause death within one (1) year of the date of the request for treatment.

The fact that a Physician has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an Injury, Sickness, or Behavioral Health Disorder, or the fact that the Physician has determined that a particular Health Care Service is Medically Necessary or medically appropriate does not mean that the procedure or treatment is a Covered Service under the Plan. The definitions of Medically Necessary and Medical Necessity used in this EOC relate only to Benefits and may differ from the way in which a Physician engaged in the practice of medicine may define Medically Necessary or Medical Necessity.

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

Member has the same meaning as Covered Person.

Member Services means the part of CareSource devoted to answering questions and assisting Members find and use the services offered by CareSource.

Network means the group of Providers who have agreed with Plan to provide Health Care Services to Covered Persons at a contracted rate.

Network Benefits, for Physician Health Care Services, are Benefits for Covered Services that are provided by or under the direction of a Physician who is a Network Provider in his or her office or at a Facility that is a Network Provider. For Facility services, these are Benefits for Covered Services that are provided at a Facility that is a Network Provider by a Physician who a Network Provider or other Network Provider. Network Benefits include Emergency Health Care Services.

Network Provider means a Provider who has entered into a contractual arrangement with us or is being used by us, or another organization that has an agreement with us, to provide certain Covered Services or certain administration functions for the Network associated with this EOC. A Network Provider may also be a Non-Network Provider for other Health Care Services or products that are not covered by the contractual arrangement with us as Covered Services. In order for a Pharmacy to be Network Provider, it must have entered into an agreement with the PIP to dispense Prescription Drugs to Covered Persons, agreed to accept specified reimbursement rates for Prescription Drugs, and been designated by the PIP as a Network Pharmacy.

Non-Covered Services means those Health Care Services that are not Covered Services under this EOC.

Non-Network Provider means a Provider who is not in CareSource's Network.

Opioid Analgesic means a controlled substance that has analgesic pharmacologic activity at the opioid receptors of the central nervous system, including the following drugs and their varying salt forms or chemical congeners: buprenorphine, butorphanol, codeine (including acetaminophen and other combination products), dihydrocodeine, fentanyl, hydrocodone (including acetaminophen combination products), hydromorphone, meperidine, methadone, morphine sulfate, oxycodone (including acetaminophen, aspirin, and other combination products), oxymorphone, tapentadol, and tramadol.

Out-of-Pocket Maximum means the maximum amount you must pay before we begin to pay 100% of the allowed amount. This limit does not include Premium Payments, Balance-Billed charges or the cost of Health Care Services not covered by the Plan.

Outpatient means relating to a patient who has not been admitted to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility.

Outpatient Services means Health Care Services other than Inpatient Services.

PIP means a pharmacy innovation partner that we contract with to administer your pharmacy Benefits. The PIP has a nationwide network of retail pharmacies, a mail service pharmacy, and a specialty pharmacy.

PCP means Primary Care Provider, which is a Network Physician, Network Physician group practice, advanced practice nurse, or advanced practice nurse group practice trained in family medicine (general practice), internal medicine, or pediatrics that you select to be responsible for providing or coordinating all Covered Services for Network Benefits.

Pharmacy means an establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

Pharmacy and Therapeutics Committee means the committee that CareSource (or CareSource's PIP) designates for, among other things, classifying Prescription Drugs into specific tier on the Prescription Drug List.

Physician means any Doctor of Medicine, "M.D.," or Doctor of Osteopathy, "D.O.," who is properly licensed and qualified by law.

Plan means the CareSource Marketplace Plan.

Pregnancy includes all of the following: prenatal care; postnatal care; childbirth; and any complications associated with Pregnancy.

Premium means the periodic fee required for each Covered Person, in accordance with the terms of the Plan.

Prescription Drug means a medication, product, or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, only be dispensed using a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of the Plan, Prescription Drugs include:

- Inhalers (with spacers);
- Insulin;
- contraceptives

The following diabetic supplies:

- Insulin syringes with needles;
- Blood testing strips - glucose;
- Urine testing strips - glucose;
- Ketone testing strips and tablets;
- Lancets and lancet devices; and
- Immunizations administered in a Pharmacy

Prescription Drug Cost means the rate the PIP has agreed to pay its Pharmacies that are Network Providers, including a dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Pharmacy that is a Network Provider.

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to periodic review and modification (generally quarterly, but no more than six (6) times per Benefit Year). You may determine to which tier a particular Prescription Drug has been assigned by contacting CareSource at the toll-free number on your ID Card or by logging onto www.CareSource.com.

Preventive Health Care Services means routine or screening Health Care Services that are designated to keep you in good health and to prevent unnecessary Injury, Sickness, or disability, including but not limited to the following as may be appropriate based on your age and/or gender: Evidence-based items or Health Care Services with an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF); immunizations for routine use in children, adolescents, and adults with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-informed preventive care screenings for infants, children, and adolescents provided in guidelines supported by the Health Resources and Services Administration (HRSA); and evidence-informed preventive care and screening for women provided in guidelines supported by HRSA and not otherwise addressed by the USPSTF. The complete list of recommendations and guidelines can be found at: http://www.HealthCare.gov/center/regulations/prevention.html and the other websites listed under Section 4: *Your Covered Services, Preventive Health Care Services* (collectively, the "List"). The List will be continually updated to reflect both new recommendations and guidelines and revised or removed guidelines.

Prior Authorization means any practice implemented by us in which Benefits for a Health Care Service is dependent upon a Covered Person or a Provider obtaining approval from us prior to the Health Care Service being performed, received, or prescribed, as applicable. This includes prospective or utilization review procedures conducted prior to providing a Health Care Service.

Provider means a duly licensed person, Pharmacy, or Facility that provides Health Care Services within the scope of an applicable license and is a person, Pharmacy, or Facility that we approve. This includes any Provider rendering Health Care Services that are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons, Pharmacies, and Facilities listed below. If you have a question about a Provider not shown below, please call the number on the back of your ID Card.

- **Alcoholism Treatment Facility** - A Facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.
- **Alternative Care Facility** – A non-Hospital health care Facility, or an attached Facility designated as free standing by a Hospital that we approve, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.
- **Ambulatory Surgical Facility** - A Facility, with an organized staff of Physicians, that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.
- **Clinical Nurse Specialists** whose nursing specialty is Mental Health Day Hospital - A Facility that provides day rehabilitation services on an Outpatient basis.
- **Dialysis Facility** - A Facility that mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. A Dialysis Facility is not a Hospital.
- **Drug Abuse Treatment Facility** - A Facility that provides detoxification and/or rehabilitation treatment for drug abuse.
- **Home Health Care Agency** - A Facility, licensed in the state in which it is located, that:

- Provides skilled nursing and other services on a visiting basis in the Covered Person's home; and
- Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

- **Home Infusion Therapy Provider** – Services that may include:
  - Skilled nursing services;
  - Prescription Drugs;
  - Medical supplies and appliances in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.
- **Hospice -** A coordinated plan of home, Inpatient, and Outpatient care that provides palliative and supportive medical and other Health Care Services to terminally ill patients, an interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician, and care is available 24 hours a day, seven days a week. A Hospice must meet the licensing requirements of the state or locality in which it operates.
- **Hospital -** A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals that:
  - Provides room and board and nursing care for its patients;
  - Has a staff with one or more Physicians available at all times;
  - Provides 24-hour nursing service;
  - Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of Sickness or Injury; and
  - Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

  The term Hospital does not include a Provider, or that part of a Provider, used mainly for:
  - Nursing care;
  - Rest care;
  - Convalescent care;
  - Care of the aged;
  - Custodial Care;
  - Educational care;
  - Treatment of alcohol abuse; or
  - Treatment of drug abuse
  - Independent Social Workers

- **Outpatient Psychiatric Facility** - A facility that mainly provides Diagnostic Service and therapeutic services for the treatment of Behavioral Health Conditions on an Outpatient basis.
- **Pharmacy** – An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order.
- **Physician** - A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), Chiropractor (spinal column and other body structures), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or optometrist (eye and sight specialist).
- **Professional Clinical Counselors**
- **Professional Counselors**
- **Psychiatric Hospital** - A facility that, for compensation of its patients, is primarily engaged in providing Diagnostic and therapeutic services for the Inpatient treatment of Behavioral Health Conditions. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Psychiatrist** – A licensed clinical psychiatrist. In states where this is no licensure law, a psychiatrist must be certified by the appropriate professional body.
- **Psychologist** - A licensed clinical psychologist. In states where there is no licensure law, the psychologist must be certified by the appropriate professional body.
- **Rehabilitation Hospital** - A Facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or Injury to achieve some reasonable level of functional ability and services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Retail Health Clinic** - A Facility that provides limited basic medical care services to Covered Persons on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.
- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, that:
    - Mainly provides Inpatient Services for persons who are recovering from an Sickness or Injury;
    - Provides care supervised by a Physician;
    - Provides 24-hour per day nursing care supervised by a full-time Registered Nurse;

  - Is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
  - Is not a rest, educational, or custodial Provider or similar place.
- **Social Worker** - A licensed clinical social worker. In states in which there is no licensure law, the social worker must be certified by the appropriate professional body.
- **Supplier of Durable Medical Equipment, Prosthetic Appliances, and/or Orthotic Devices**
- **Urgent Care Center** - A licensed health care Facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Health Plan means a health plan offering on the Marketplace that satisfies the requirements set forth under the Affordable Care Act at 42 U.S.C. § 18021(a)(1).

Record means any written, printed, or electronically recorded material maintained by a Provider in the course of providing Health Care Services to a patient concerning the patient and the services provided. Record also includes the substance of any communication made by a patient to a provider in confidence during or in connection with the provision of Health Care Services to a patient or information otherwise acquired by the Provider about a patient in confidence and in connection with the provision of Health Care Services to a patient.

Regular Basis means you have received Health Care Services in the last twelve (12) months from a PCP or Provider.

Rescission means a cancellation of coverage that has retroactive effect. Rescission is allowed if it is due to Fraud or intentional misrepresentation of a material fact. See Section 11 – *When Coverage Ends – Recession* for more information.

Residential Treatment Program means Behavioral Health Treatment, which does not meet the definition of Inpatient Hospital care, but requires a patient to reside at a certified or licensed residential treatment facility for the duration of the treatment period. Treatment programs are designed to treat groups of patients with similar Behavioral Health Disorders, living within a supportive 24-hour community (*e.g.*, a 28-day alcohol rehabilitation program).

Responsible Party means the person responsible for payment of Premiums, Copayments, Coinsurance and Deductibles.

Rider/Enhancement means any attached written description of additional Covered Services not described in Sections 1 – 12 of this EOC. Covered Services provided by a Rider/Enhancement may be subject to payment of additional Premiums by the Covered Person. Riders/Enhancements are subject to all conditions, limitations, and Exclusions of the Plan except for those that are specifically amended in the Rider/Enhancement.

Schedule of Benefits means the written description of the Benefits that are available for Covered Services that is provided to you when you are enrolled under the Plan.

Semi-private Room means a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Service, the difference in cost between a Semi-Private Room and a private room is a Benefit only when a private room is Medically Necessary or when a Semi-private Room is not available.

Service Area means the geographic area we serve approved by the appropriate regulatory agency and in which we have Network Providers. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Sickness means physical sickness, disease or Pregnancy. The term Sickness as used in this EOC does not include Behavioral Health Disorders or Substance Use Disorders, regardless of the cause or origin of the Behavioral Health Disorder or Substance Use Disorder.

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

Specialist means a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Stabilize means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of a Covered Person's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

In the case of a woman having contractions, "Stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

Substance Use Disorder means those alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association).

Substance Use Disorders Treatment means Health Care Services for the diagnosis and treatment of Substance Use Disorders. Substance Use Disorders Treatment includes Health Care Services for the prevention, treatment, and rehabilitation of Covered Persons who abuse alcohol or other drugs.

Telemedicine Health Care Services means Health Care Services delivered by the use of interactive audio, video or other electronic media, including medical examinations, consultations and evaluations related to Behavioral Health Care Services.

Terminal Condition means an irreversible, incurable, and untreatable condition that is caused by disease, illness, or injury and will likely result in death. A Terminal Condition is one in which there can be no recovery, although there may be periods of remission.

Terminal Illness means a medical condition for which a Covered Person has a medical prognosis that his or her life expectancy is six (6) months or less if the condition runs its normal course, as certified by the Covered Person's Physician.

Therapeutic Abortion means an abortion performed to save the life or health of a mother, or as a result of incest or rape.

Therapeutically Equivalent means Prescription Drugs that can be expected to produce essentially the same therapeutic outcome and toxicity.

Third Party means any individual, automobile insurance company, or public or private entity against which a Covered Person or the Covered Person's estate has a Tort Action.

Tort Action means a civil action for Injury, death, or loss to a Covered Person. "Tort action" includes any claim for damages for Injury, death, or loss to person, whether or not a lawsuit is pending, or a Claim in connection with uninsured or underinsured motorist coverage, but does not include a civil action for breach of contract or another agreement between persons.

United States means the country commonly called the United States (US or U.S.) or America, consisting of fifty (50) states and the Federal District of Washington D.C.

Unproven Service or Unproven means Health Care Services, including medications that are not consistent with conclusions of prevailing medical research, that demonstrate that the service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs: (a) well-conducted randomized controlled trials (two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received) or (b) well-conducted cohort studies (patients who receive study treatment are compared to a group of patients who receive standard therapy and the comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures, and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one (1) year of the request for treatment) we may determine that an Unproven Service meets the definition of a Covered Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Services means those Health Care Services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay, but that does

not pose a threat to the life, limb, or permanent health of the Covered Person, and may include such Health Care Services provided by Non-Network Providers.

Utilization Management means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the plan. The system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures, and retrospective review.

This Evidence of Coverage and Health Insurance Contract ("EOC") constitutes a contract between you and CareSource for the Plan. This EOC takes the place of any other issued to you by CareSource on a prior date.

This EOC is delivered in and governed by the laws of the State of Ohio. All coverage under this Plan shall begin at 12:00 midnight and shall end at 11:59:59 Eastern Standard Time.

Erhardt H. Preitauer
President and Chief Executive Officer
CareSource

CareSource.com/marketplace/OH

OH-EXCM-1052

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CareSource®

Health Care with Heart

MARKETPLACE PLAN

Dental, Vision and Fitness

Evidence of Coverage And Health Insurance Contract Rider

Ohio

OH-EXCM-1053

ADULT DENTAL AND VISION BENEFITS AND FITNESS RIDER

This Rider is a part of the Evidence of Coverage (EOC) to which it is attached. It is subject to all of the terms, conditions, exclusions and limitations of the EOC which are not in conflict with the terms, benefits, exclusions and limitations of this Rider.

CareSource Dental and Vision Benefits and Fitness Programs include the Benefits and services described in this Rider. They are offered at an extra cost to you, as further described in the Schedule of Benefits and may be referred to as "Adult Dental", "Adult Vision Benefits", and "Adult Fitness Programs". These Dental and Vision Benefits, and Fitness Programs are not Essential Health Benefits.

NOTE: Dental and Vision Benefits for pediatric members are not available under this Rider. Please reference Section 4 – *Your Covered Services* of your EOC for pediatric dental and vision Benefits.

Network of Providers

CareSource utilizes a Network for the provision of covered Dental and Vision Benefits, and Fitness Programs. We will only provide coverage for Dental and Vision Benefits, and Fitness Programs when you use a dentist, optometrist, ophthalmologist, or other appropriate Provider within our Network. We do not cover dental, vision, and fitness program services provided by Non-Network Providers.

1. DENTAL BENEFITS

CareSource's Dental Benefits include Preventive and Diagnostic (cleanings and exams), (X-rays), Basic Restorative (fillings) and Major Restorative (extractions, dentures and crowns) dental services. Two Preventive visits are allowed each Benefit Year for cleanings and oral examination. All dental Benefits under this Section are subject to a combined $800 limit per Benefit Year.

Preventive and Diagnostic Dental Benefits:

- Limited oral exam – problem focused (Emergency dental exam)
- Comprehensive oral exam
- Intraoral – Complete Series (1 each 36 months)
- Intraoral – Periapical first film
- Intraoral – Periapical each additional film
- Intraoral – Occlusal film
- Bitewing – Single Film (all bitewing X-rays – 1 series per Benefit Year)
- Bitewings – Two Films
- Bitewings – Three Films
- Bitewings – Four Films
- Panoramic Film (1 each 36 months)
- Prophylaxis – Adult (1 each 6 months)

Basic Restorative Dental Benefits

- Amalgam – One Surface
- Amalgam – Two Surface
- Amalgam – Three Surface
- Amalgam – Four or More Surfaces
- Resin Based Composite – One Surface, Anterior
- Resin Based Composite – Two Surface – Anterior

- Resin Based Composite – Three Surface – Anterior
- Resin Based Composite – Four or More Surfaces or Involving Incisal Angle
- Resin Based Composite – One Surface – Posterior
- Resin Based Composite – Two Surface – Posterior
- Resin Based Composite – Three Surface
- Resin Based Composite – Four or More Surfaces
- Extraction – Erupted Tooth or Exposed Root

Major Restorative Dental Benefits:

- Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)
- Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)
- Endodontic Therapy, Molar Tooth (Excluding Final Restoration)
- Surgical Removal of an Erupted Tooth
- Removal of Impacted Tooth – Soft Tissue
- Removal of Impacted Tooth – Partial Bony
- Removal of Impacted Tooth – Completely bony
- Removal of Impacted Tooth – Completely bony with Complications
- Surgical Removal of Residual Roots
- Complete Upper Denture
- Complete Lower Denture
- Maxillary Partial Denture – Resin Base
- Mandibular Partial Denture – Resin Base
- Denture relining or rebasing (1 every 36 months)
- Denture adjustment (covered 1 every 36 months but if occurring within 6 months of placement of dentures, must be provided by the dentist without charge)
- Crown – resin-based composite (indirect)
- Crown - 3/4 resin-based composite (indirect); Does not include facial veneers
- Crown - resin with high noble metal
- Crown - resin with predominantly base metal
- Crown - resin with noble metal
- Crown - porcelain/ceramic substrate
- Crown - porcelain fused to high noble metal
- Crown - porcelain fused to predominantly base metal
- Crown - porcelain fused to noble metal
- Crown - 3/4 cast high noble metal
- Crown - 3/4 cast predominantly base metal
- Crown - 3/4 cast noble metal
- Crown - 3/4 porcelain/ceramic; Does not include facial veneers.
- Crown - full cast high noble metal
- Crown - full cast predominantly base metal
- Crown - full cast noble metal
- Recement inlay, onlay, or partial coverage restoration
- Recement cast or prefabricated post and core
- Recement crown
- Prefabricated resin crown

- Protective Restoration; Direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, or prevent further deterioration. Not to be used for endodontic access closure, or as a base or liner under a restoration.
- Core buildup, including any pins; Refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure. This should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation.
- Pin retention - per tooth, in addition to restoration
- Post and core in addition to crown, indirectly fabricated; Post and core are custom fabricated as a single unit.
- Each additional indirectly fabricated post - same tooth; To be used only with Code D2952
- Prefabricated post and core in addition to crown; Core is built around a prefabricated post. This procedure includes the core material.
- Post removal
- Each additional prefabricated post - same tooth; To be used only with Code D2954
- Crown repair necessitated by restorative material failure

Exclusions.

The Plan does not cover the following:

- Services and treatment not prescribed by or under the direct supervision of a dentist., except for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Services and treatment which are not Medically Necessary or which do not meet generally accepted standards of dental practice;
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
- State or territorial taxes on dental services performed;
- Those submitted by a dentist, which is for the same services performed on the same date for the same Covered Person by another dentist;
- Those performed by a dentist who is compensated by a Facility for similar covered services performed for Covered Persons;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Gold foil restorations;
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
- Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (Inpatient or Outpatient);
- Charges by the Provider for completing dental forms;
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;

- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Use of material or home health aides to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Sealants for permanent teeth;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal bleaching;
- Nitrous oxide;
- Oral sedation;
- General anesthesia;
- Intravenous sedation;
- Topical medicament center;
- Orthodontic care for a Covered Person or spouse;
- Bone grafts when done in connection with extractions, apicoetomies or non-covered/non eligible implants.

2. VISION BENEFITS

Network of Providers

The Benefits available to you under this Section are administered by EyeMed™. The management and other services that EyeMed™ provides include, among others, maintaining and managing the Network Providers who will provided Covered Services to you under this Section. You must use an EyeMed™ Network Provider in order to receive Benefits under this Section. If you do not use an EyeMed™ Network Provider to receive Health Care Services under this Section, then you will be responsible for all costs, and such Health Care Services will be considered Non-Covered Services. Please call 1-833-337-3129 for help locating an EyeMed™ Network Provider and for additional information and details.

IMPORTANT: IF YOU OPT TO RECEIVE VISION CARE SERVICES OR VISION MATERIALS THAT ARE NOT COVERED BENEFITS UNDER THIS PLAN, A PARTICIPATING NETWORK PROVIDER MAY CHARGE YOU HIS OR HER NORMAL FEE FOR SUCH SERVICES OR MATERIALS. PRIOR TO PROVIDING YOU WITH VISION CARE SERVICES OR VISION CARE MATERIALS THAT ARE NOT COVERED BENEFITS, THE VISION CARE PROVIDER WILL PROVIDE YOU WITH AN ESTIMATED COST FOR EACH SERVICE OR MATERIAL UPON REQUEST.

Covered Services:

1. **Comprehensive Eye Exam with Dilation, if Medically Necessary**. Limited to one per Benefit Year. Cost share applies.
2. **Eyewear**: Covered in Full up to a $250 allowance per benefit year, limited to one pair of glasses or contacts per Benefit Year.
    a. Eyeglasses (includes materials only)
        i. Frames, lens & options: 20% discount on balance after $250 allowance.
    b. Contact lenses (includes materials only)
        i. Conventional - 15% discount balance after $250 allowance.

ii. Disposable - No discount after $250 allowance.

3. **Low-Vision:** Low vision is a significant loss of vision but not total blindness.
   a. **Supplemental Testing:** Diagnostic evaluation beyond a comprehensive eye examination including, but not limited to, an ocular function assessment, measurements, visual field evaluations. Limited to one per Benefit Year.
   - **Low Vision Aids:** Includes, but is not limited to spectacle-mounted magnifiers, hand-held or spectacle-mounted telescopes, hand-held and stand magnifiers, and video magnification. Limited to one per Benefit Year.
4. **Retinal Imaging Benefit**: Cost share applies. Limited to one per Benefit Year.
5. **Medically Necessary Contact Lenses:** In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, niridia, corneal disorders, post-traumatic disorders, irregular astigmatism. Medically Necessary contact lenses are dispensed in lieu of other eyewear.

   In the event that contact lenses are determined to be Medically Necessary, the contact lenses and associated services, including fit and follow-ups, will be Covered In Full with no limitation on the number of follow-ups required.

Additional services:

The following are services you have access to as a Covered Person, but shall not be considered a Benefit under the Plan:

1. Laser Vision Correction (Lasik or PRK from U.S. Laser Network): The Plan will not provide Benefits for laser vision correction services. However, Members may receive 15% off retail price or 5% off promotional price of the cost of laser vision correction services.
2. Additional Pairs Benefit: The Plan will only provide Benefits for one pair of glasses or contact lenses. You may purchase additional eyewear at your own cost, and you may receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses upon exhaustion of the Benefits above.

Exclusions

The Plan does not cover the following:

- Services and materials not meeting accepted standards of optometric practice;
- State or territorial taxes on vision services performed;
- Visual therapy;
- Replacement of lost/stolen eyewear;
- Non-prescription (Plano) lenses;
- Two pairs of eyeglasses in lieu of bifocals; or
- Insurance of contact lenses.

3. ACTIVE&FIT FITNESS PROGRAM

The Plan provides covered adults age 18 and older with the ability to enroll in select fitness centers for the Benefit Year while enrolled in the Plan. Using the Active&Fit fitness program is voluntary, and is provided at no cost to you. Enrollment may give you access to cardiovascular equipment, strength training equipment, certain fitness classes, and other amenities, such as saunas, locker rooms, and pools, where available.

However, if you would rather exercise at home instead of at a fitness center, then up to two home fitness kits, which may include materials and instructions, will be provided free of charge. Home fitness kits allow you to exercise in the convenience of your own home.

Enrollment in select fitness or exercise clubs or facilities or receiving home fitness kits requires you and other covered adults to meet other eligibility requirements. For more information on this program, eligibility requirements, how to enroll, available services in your area, and exclusions and limitations, please call Active&Fit member services at the number found on the back of your ID card, or at ActiveandFit.com.

Limitations:

- Fees paid under this program, if required, do not count towards your Annual Out-of-Pocket Maximum, are non-refundable, are not prorated, and may be required to be paid to a third party and not CareSource.

- Available fitness or exercise centers \ may vary and change at any time. Enrolled adults may not have access to all services offered by the fitness center and some services may require the purchase of upgraded memberships.

- Prior to enrollment, please verify with the fitness center what services are included as part of this program and what services (if any) would require additional fees.

- Not all Covered Persons may be eligible to participate in this program. Available fitness centers may have certain restrictions for enrollment, such as age requirements.

- Enrollment in this program is limited to the current Benefit Year and while Covered Persons are enrolled in the Plan. If you disenroll or are terminated from the Plan during the Benefit Year, then you will no longer be able to access fitness centers.

- Each enrollee may choose fitness center membership or home fitness kits, but may not select both.

This Rider amends and is incorporated into the contract between you and CareSource. This Rider takes the place of any other issued to you by CareSource on a prior date. All coverage under this Rider shall begin at 12:00 midnight and shall end at 11:59:59 Eastern Standard Time.

Erhardt H. Preitauer
President and Chief Executive Officer
CareSource

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