Indiana Marketplace

2026 Evidence of Coverage

CareSource®

Marketplace Plan
Indiana
Evidence of Coverage
Plan Year 2026

CareSource is a
Qualified Health Plan Issuer in the
Health Insurance Marketplace

Evidence of Individual Coverage and

Health Maintenance Organization Contract Marketplace Plan

CareSource Indiana, Inc.

251 N. Illinois St.
Suite 300
Indianapolis, IN 46204

Please read this EOC carefully. If you are not satisfied, return this Evidence of Individual Coverage and Health Maintenance Organization Contract (EOC) to us within ten (10) calendar days after you received it. The EOC will be deemed delivered three (3) calendar days after it was deposited in the United States mail with first class postage prepaid, or when it is personally delivered, to the address shown above. Upon return, this EOC will be deemed void and any Premium will be refunded. In such event, any Health Care Services received during this ten (10) calendar day period are solely your responsibility.

Information regarding this Plan may be obtained by contacting CareSource at: 1-833-230-2099 or CareSource.com/marketplace.

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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 since 1989. Our mission is to make a difference in peoples' lives by improving their health care. It is the essence of our company. Our unwavering dedication to that mission is a hallmark of our success.

We are offering CareSource as a Qualified Health Plan. This Plan is available through 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 our 24-Hour 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 1-833-230-2099.

Sincerely,

Erhardt H. Preitauer
President and Chief Executive Officer
CareSource Indiana, Inc.

SECTION 1 – INTRODUCTION

This document is your ***Evidence of Coverage (EOC)*** which outlines your policy benefits, coverage details, exclusions, and termination provisions under the policy. Your EOC should be read together with your Schedule of Benefits in order to understand the comprehensive health benefits available to you under your plan.

The EOC describes your rights, responsibilities, and obligations as a Covered Person under the Plan and details:

- How the Plan works and describes the Covered Services,
- Conditions and limits related to Covered Services,
- Health Care Services that are not covered by the Plan, and
- Annual Deductible, Copayments, and Coinsurance payments required when you receive Covered Services.

Please carefully read and review the entire EOC. If you have any questions about the information in the document, contact CareSource online or by phone at the telephone number below. Please review Section 2: *Definitions* of the EOC to ensure that you understand the words and defined terms that are used throughout the EOC. These definitions will help you understand the EOC.

Also, note that some health services under your policy are subject to Prior Authorization and approval before they may be reimbursed. Your Provider should get any necessary Prior Authorizations from us. You can see the list of services that require a Prior Authorization by going to the Tools and Resources page for your plan on CareSource.com and clicking on the Prior Authorization List link on the Quick Links menu at the bottom left of the page. If you have any questions regarding your Benefits or which services require Prior Authorization, please call Member Services.

Throughout this document, you will find statements that encourage you to contact us for further information. Whenever you have a question or concern, 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.

CareSource provides, at no cost, oral and written interpretation services to be used for those who may speak another language and do not understand or readily use English within their home. Please call Member Services for more information.

CareSource Contact Information:
Member Services: 833-230-2099
24-Hour Nurse Advice Line: 866-206-7880
Online: CareSource.com/marketplace
Address: P.O. Box 8730 Dayton, OH 45401 ATTN: Member Services

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 Riders/Enhancements or Amendments at 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 2: *Definitions*.

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. 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 other documentation provided to you by the Plan. 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 2: *Definitions*. You should refer to Section 2 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 are defined in Section 2: *Definitions*.

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 and 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 3: *How the Plan Works, Choose a PCP.*

Your Financial Responsibility

You must pay Copayments, Coinsurance, and the Annual Deductible for many Covered Services. See Section 3: *How the Plan Works* and the Schedule of Benefits 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 the 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 7: *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, 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 healthcare.gov. Additional information on how to enroll in a plan is available at 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 Indiana and reside within the Plan's Service Area.

If you are seeking coverage outside of 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 Indiana 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 show proof that you meet and continue to meet the conditions above. Coverage under this Plan is available to you no matter what your health condition is.

Dependents who are eligible to participate in the Plan include:

- Your legally recognized spouse.
- 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.
- Your natural blood related child, stepchild, 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.
- 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.

Proof of a child's incapacity must be furnished to us within thirty-one (31) days of the child's attainment of the limiting age. We may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two (2) year period, we may require subsequent proof not more than once per Benefit Year.

The Plan 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 for thirty-one (31) days from the child's date of birth. No Premium will be charged for the first thirty-one (31) calendar days. 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. 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 legal custody or guardianship is awarded by the court or the date the child was placed in your foster care. Coverage under the Plan will begin on the date the court granted legal custody or guardianship or the date the child was placed in your custody.

Unless otherwise provided for in Section 3: *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 submit an 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, and such coverage will take effect not later than the effective date of termination of this Plan. Please see Section 10: *Coordination of Benefits* for additional information.

Application and Enrollment for CareSource Coverage

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 healthcare.gov. You can find more information on the Marketplace website about eligibility criteria. You can also get help with your enrollment 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.

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, the Marketplace will confirm your eligibility through the website application process or in writing. 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 through direct enrollment with CareSource, 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 CareSource, 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, 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 advise us of the 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 us (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 9: *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 a payment that is sufficient to Effectuate your coverage has been received, we will provide coverage for 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.
- A Dependent reaches the limiting age.
- You or anyone on the policy becomes entitled to Medicare Part A or enrolls in Medicare Part B.
- You receive health insurance coverage through another payor, be it employment-based coverage or other coverage.

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, the Marketplace will give you information about the open enrollment process. If you are enrolled in the Plan through the Marketplace, you cannot choose another Qualified Health Plan once you have enrolled unless: you are still within the annual open enrollment period; or 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. If enrolling directly with CareSource, individuals will qualify for a special enrollment period any time they meet the qualifications throughout the plan year.

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

- Loss of minimum essential coverage due to circumstances such as: loss of a job; voluntarily quitting a job; divorce or legal separation; no longer residing in your plan's service area; no longer a Dependent; or loss of coverage under parent's plan among other circumstances;
- Enrollment in any non-calendar year group health plan or individual health insurance coverage;

- Loss of pregnancy related coverage or loss of pregnancy related services provided through the Children's Health Insurance Program "unborn child" option;
- Loss of Medicaid coverage;
- 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;
- 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 of the Marketplace or other entity providing enrollment assistance or conducting enrollment services;
- A Qualified Health Plan or other health plan violates a material provision of its contract with you;
- Gaining access to new Qualified Health Plans or other health plan as a result of a permanent move;
- Victim of domestic abuse or spousal abandonment or is a Dependent of a victim of domestic abuse or spousal abandonment;
- Being determined ineligible for Medicaid or the Children's Health Insurance Program;
- Gaining a new immigration status as a citizen, national, or lawfully present;
- Gaining access to an individual Health Reimbursement Arrangement (HRA), or is newly provided a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA);
- A Qualified Health Plan is decertified by the Department of Insurance and no longer can provide coverage to you or your Dependent;
- Loss of a Dependent on the plan through divorce or legal separation; or
- Your death or the death of a Dependent.

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:

- Release from incarceration;
- Newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or a change in eligibility for cost-sharing reductions;
- 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;
- An individual or their Dependents demonstrates to the Marketplace, that the individual meets other exceptional circumstances as the Marketplace may provide;
- 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

- 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.

SECTION 2 – DEFINITIONS

What this section includes:

- Definitions of terms used throughout this EOC

Active Course of Treatment means any of the following:

- An ongoing course of treatment for a life-threatening condition, including terminal illness, defined as a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- 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;
- Pregnancy, through the postpartum period;
- 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;
- A chronic illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time;
- An ongoing course of institutional or inpatient care from the Provider or Facility; or
- Scheduled non-elective surgery from the Provider, including receipt of postoperative care from such Provider or Facility with respect to such a surgery.

Administrative Denial means the denial by CareSource for nonmedical reasons of a health Provider Facilities or Provider's claim for reimbursement.

Adverse Benefit Determination means a decision by CareSource to deny, reduce, or terminate benefit coverage of a health care service furnished or proposed to be furnished to a Member on the grounds that the health care service:

- Is not Medically Necessary, appropriate, effective, or efficient;
- Is not being provided in or at an appropriate health care setting or level of care;
- Is experimental or investigational;
- 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.

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;
- Copayments and coinsurance amounts for Covered Services available by an optional Rider/Enhancement, unless specifically stated otherwise in the 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 in response to Pervasive Developmental Disabilities, including Autism Spectrum Disorder.

Authorization means a determination by a Utilization Review Entity that a health care service has been reviewed and based on the information provided, satisfies the utilization review, payment will be made for the health care service.

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 (DSM)* (American Psychiatric Association): Autism; Asperger's Disorder; or other condition that is specifically categorized as a pervasive developmental disorder in the DSM.

Basic Health Care Services means Essential Health Benefits.

Behavioral Health Disorder means those mental health, substance use disorder, and development disorder diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association).

Behavioral Health Care Services means Health Care Services for the diagnosis and treatment of Behavioral Health Disorders that are listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association) unless those services are specifically excluded. The fact that a condition or disorder is listed in the current *DSM* 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.

Binder Payment means the amount required to become eligible for Benefits, which includes your first month(s) of Premium as well as any unpaid Premiums from previous enrollments within the preceding12-month period.

Blood Services means the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a Members own blood only when it is stored and used for a previously scheduled procedure.

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 Pharmacy Benefit Manager (PBM).

Business Day means Monday through Friday, excluding any state or federal holiday observed by

CareSource.

Business Hours means Monday through Friday, 8 a.m. to 5 p.m., excluding any state or federal holiday observed by CareSource.

24-Hour Nurse Advice Line means CareSource's Nurse Advice Line, for non-emergency health situations, which Members can call 24 hours a day, seven days a week, including holidays. The call is free and confidential. Members speak directly with a registered nurse about their symptoms or health questions. The nurse will quickly assess their situation and help them choose the most appropriate action. A fax will then be sent to the Member's PCP to help him or her coordinate better care for the Member.

Chiropractor means any doctor of chiropractic who is duly licensed and qualified to provide chiropractic services.

Chiropractor Services means any Covered Services rendered by a Chiropractor within the scope of their license including but not limited to the office visit, manipulation therapy, and physical therapy. Benefit limits will apply based on the type of services rendered. Please see Section 5: *Your Covered Services, Rehabilitative Services – Outpatient Therapy* and Section 5: *Your Covered Services, Habilitative Services* for applicable limits, such as manipulation therapy and physical therapy.

Circumstances Beyond the Plan's Control means the following:

- The failure of a Non-Network Provider to provide within fifteen (15) calendar days of filing a Standard Internal Appeal or Grievance information that is requested by the Plan and is necessary to adequately review and investigate a Standard Internal Appeal or Grievance; or
- The failure of a Covered Person to provide additional information requested by the Plan that is necessary to adequately review and investigate the standard Internal Appeal or Grievance within fifteen (15) calendar days of filing the Standard Internal Appeal or Grievance.

Claim means a request for a Benefit (including reimbursement of an Eligible Expense) made to us by your Provider or you.

Clinical Criteria means written policies, screen procedures, drug formularies or lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and any other criteria or rationale used by the Utilization Review Entity to determine the medical necessity of a health care service.

Clinical Peer means (A) a physician who holds a current and valid license under IC 25-1-21, if reciprocity exists, or holds a license that is part of a compact in which Indiana has entered; (B) is certified in the same specialty as the Physician under review as recognized by: the American Board of Medical Specialties or the American Osteopathic Association; and (C) if the review specifically concerns subspecialty care, is certified in the same subspecialty as the Physician under review, as recognized by: the American Board of Medical Specialties or the American Osteopathic Association.

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.

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 3).

Congenital Anomaly means a physical developmental defect that is present at birth and is identified within the first twelve (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 3).

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 CareSource's 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: *Introduction, Eligibility Requirements*.

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.

Emergency Health Care Services means a health care service that is provided in an emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses average knowledge of health and medicine to:

- Place an individual's health in serious jeopardy;
- Result in serious impairment to the individual's bodily function; or
- Result in serious dysfunction of any bodily organ or part of the individual.

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 Medical Services means an integrated medical care delivery system in which emergency medical responders, emergency medical technicians, advanced emergency medical technicians and paramedics provide emergency and nonemergency medical care to protect against the loss of life or aggravation of illness or injury:

- During an emergency response;
- While transporting a patient in a ground or air Ambulance outside of a Hospital, a health facility, a mental health facility, or an urgent care facility; or
- As part of a mobile integrated healthcare program.

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 as further defined by the Indiana Department of Insurance.

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 I, II or III 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.

Facility means a Hospital, Ambulatory Surgical Facility, or birthing center registered under Indiana Revised Code § 16-21-2; a health care facility licensed under Indiana Revised Code § 16-28-2 or § 16-28-3; a Home Health Agency licensed under Indiana Revised Code § 16-27-1; or a Hospice licensed under Indiana Revised Code § 16-25-3; a freestanding cardiac catheterization facility; a freestanding birthing center; a freestanding or mobile diagnostic imaging center; or 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; and residential facilities licensed under Indiana Revised Code § 16-28-2 or § 16-28-3 and defined by 410 Indiana Administrative Code 16.2-1.1-62.

Family Planning Services means 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 the Plan 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 Pharmacy Benefit Manager (PBM).

Grace Period means the time period set forth in Section 3: *How the Plan Works*.

Habilitative Services or Habilitative means those Health Care Services that help a person keep, learn, or improve skills and functioning for daily living. An example of Habilitative Services includes 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 a 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.

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; and 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.

ID Card means the CareSource Identification Card that you will receive when you are enrolled under the Plan.

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, Inpatient hospice, long term acute care, respite care, or Inpatient Rehabilitation Facility.

Inpatient Services means Health Care Services relating to a patient admitted to a Hospital, Skilled Nursing Facility, Inpatient hospice, long term acute care, respite care 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, Inpatient hospice, long term acute care, respite care, or Inpatient Rehabilitation Facility.

Marketplace means the health insurance benefit exchange established by the Affordable Care Act for the State of Indiana.

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 our 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 with finding and using the Benefits and services offered by CareSource.

Network means the group of Providers who have agreed with the 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 is 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 a Network Provider, it must have entered into an agreement with the PBM to dispense Prescription Drugs to Covered Persons, agreed to accept specified reimbursement rates for Prescription Drugs, and been designated by the PBM 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 the Plan'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, amounts paid for adult vision or fitness benefits, 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.

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 PBM) designates for, among other things, classifying Prescription Drugs into specific tiers on the Prescription Drug List. For more information about what the Pharmacy and Therapeutics Committee does, see Section 6: *Prescription Drugs*.

Pharmacy Benefit Manager (PBM) means the organization we partner with to make sure your Pharmacy Benefits work correctly. The PBM has a nationwide network of retail pharmacies, a mail service pharmacy and a specialty pharmacy. See Section 6 for more information about what the PBM does for you.

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 this Plan, Prescription Drugs include:

- Immunizations administered in a Pharmacy;
- Inhalers (with spacers);
- Insulin;
- And the following diabetic supplies:
    - Insulin syringes and needles
    - Blood glucose testing strips and meters
    - Urine glucose testing strips
    - Ketone testing strips and tablets
    - Lancets and lancet devices
    - Continuous glucose monitors

Prescription Drug Cost means the rate the PBM 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 medications, products or devices that have

been approved by the U.S. Food and Drug Administration into tiers. This list is subject to periodic review and modification (generally quarterly). You may determine to which tier a particular Prescription Drug has been assigned by contacting CareSource Member Services at the toll-free number on your ID Card or by using the Find My Prescriptions tool on 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: HealthCare.gov/center/regulations/prevention.html and the other websites listed under Section 5: *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 the process by which a Utilization Review Entity determines the Medical Necessity of an otherwise covered Health Care Service before the Health Care Service is rendered. The term includes a Utilization Review Entity's requirement that a Covered Person or health care Provider notify the Utilization Review Entity 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 the Plan approves. This includes any Provider rendering Health Care Services that is 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, please call the number on the back of your ID Card.

- **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.
- **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.
- **Substance Use Treatment Facility** - A Facility that provides detoxification and/or rehabilitation treatment for substance use.
- **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; or
  - Educational care.
- **Community Behavioral Health Center** – A provider group that mainly provides Behavioral Health Care Services for the treatment of Behavioral Health Disorders on an Outpatient basis. 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).

- **Psychiatric Hospital** - A facility that is primarily engaged in providing Behavioral Health Care Services for the Inpatient treatment of Behavioral Health Disorders. 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. These facilities may be considered Institutions of Mental Disease (IMD).
- **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 and may also be referred to as a Convenience Care Clinic. 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 a 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 12: *When Coverage Ends, Rescission* for more information.

Residential Treatment Program means Behavioral Health Care Services, which do not meet the definition of Inpatient Hospital care but requires a patient to reside at an appropriately certified or licensed residential treatment facility for the duration of the treatment period. Residential Treatment Programs are designed to treat groups of patients with similar Behavioral Health concerns, living within a congregate living community with 24-hour support.

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 through 13 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. 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 (DSM)* (American Psychiatric Association).

Teladoc are Providers we have negotiated the ability to provide Telehealth Services to our Members. As with our other Network Providers, these partners are subject to change and may limit the number of patients they will accept and may have other limitations and restrictions. There is not a guarantee or assurance that you will be able to receive Telehealth Services from any certain Teladoc Provider during the Benefit Year. Services offered by each Teladoc Provider may vary and may not include certain specialty services including Behavioral Health Services.

Telehealth Services means the delivery of health care services using interactive electronic communications and information technology, in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), including: secure videoconferencing; store and forward technology; remote patient monitoring technology; or services delivered by audio only; between a provider in one location and a patient in another location.

The term does not include the use of the following unless the practitioner has an established relationship with the patient: electronic mail, an instant messaging conversation, fax, internet questionnaire, or internet consultation.

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 necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman’s life; if the fetus is diagnosed with a lethal fetal anomaly; or if the pregnancy is a result of incest or rape, performed in accordance with the constraints and requirements set forth in Indiana Code 16-34-2-1.

Therapeutically Equivalent means Prescription Drugs that can be expected to produce essentially the same therapeutic outcome with essentially the same degree of safety.

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.

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.

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.

Utilization Review Entity means an individual or entity that performs Prior Authorization for one (1) or more of the following: an employer who employs a covered individual; a health plan; a preferred provider organization; any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, prescription drug, or other health benefits to a covered individual.

SECTION 3 – HOW THE PLAN WORKS

This section includes information on:

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

Benefits

The Service Area

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.

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.

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 findadoctor.caresource.com. A printed directory may be provided to you free of charge. Find A Doctor is updated at least monthly.

Covered Services From Network Providers

The Plan provides 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, with exception to the services as explained in this section, elsewhere in this Evidence of Coverage, and as required by law.

Services Provided by Non-Network Providers

While the Plan expects you to receive Health Care Services from Network Providers, there are situations where the Plan will cover Health Care Services from Non-Network Providers. When this is allowed, these Benefits will be considered Covered Services and any applicable Copayment, Coinsurance, Annual Deductible, or Annual Out-of-Pocket Maximum requirements will be the same as if you obtained the Health Care Services from a Network Provider.

Health Care Services you receive from Non-Network Providers are Covered Services only if:

- You receive Emergency Health Care Services; which includes Emergency Ambulance Services;
- 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 3;
- You receive Health Care Services from a Non-Network Provider (such as an anesthesiologist, pathologist, Emergency Room Physician, consulting Physician, or radiologist) while you are in a Hospital or other Facility that is a Network Provider; 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 Non-Network Provider must obtain our Prior Authorization.

With the exception of Emergency Health Care Services and services provided by a Non-Network Provider while in a Network Facility, for Health Care Services provided by Non-Network Providers or Facilities:

- You or the Non-Network Provider are required to obtain a Prior Authorization before receiving the services. Failure to obtain a Prior Authorization will result in the services being considered Non-Covered Services;
- Will be payable at the Network level and are limited to the Maximum Allowable Amount.
- You will be responsible for filing the Claim;
- You will also be responsible for payment of any:
    - Non-Covered Services;
    - Services that are not Medically Necessary; and/or
    - The difference between the amount(s) charged and the Allowed Amount(s) plus any Deductible and/or Coinsurance/Copayment.

When delivered by a Non-Network Provider or Facility, Emergency Health Care Services, Emergency Ambulance Services, and services provided while in a Network facility, are handled somewhat differently:

- You or the Non-Network Provider will need to obtain a Prior Authorization for non-network provided services in a network facility, however, you will not need a Prior Authorization for Emergency Health Care Services or Emergency Ambulance Services;
- You will be held harmless from surprise medical bills and Non-Network Providers will not be allowed to balance bill you unless you **consent to the out-of-network care**;
    - **Consent to out-of-network** care is limited to scenarios where a Non-Network Provider is providing ancillary services (such as emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a Physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists) while in a Participating Facility. The Provider is required to provide you notice of their network status and an estimate of charges at least 72 hours prior to receiving out-of-network services, or the day the appointment is made if the service is scheduled less than 72 hours in the future. You will have the choice to consent to this or not. If you consent, the Non-Network Provider will be allowed to bill you for any amount not covered by us.

What You Must Pay

Premium Payments

Your monthly payment may be paid online at CareSource.com/mppay, by calling 1-833-230-2099, or by mailing to CareSource at P.O. Box 6065, Indianapolis, Indiana 46206-6065. We will provide you with other important information about 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 the Benefit Year, which in certain circumstances may be less than twelve (12) months. We reserve the right to change the Premium annually. You will receive sixty (60) calendar days' notice of any change to the Premium amount, unless otherwise directed by law or the Marketplace.

If the 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.

Grace Period

Once you have paid your Binder Payment and Effectuated your coverage, you will be eligible for a Grace Period for the payment of any subsequent Premiums. The Grace Period is triggered as the result of you not paying your Premium in full by the due date and will impact how the Plan processes and pays your claims during this period. The specifics of the Grace Period vary depending upon whether or not you are receiving an Advance Premium Tax Credit (APTC).

If you are receiving APTC at the time you enter the Grace Period, your Grace Period will be the three (3) consecutive months following your missed Premium payment. During this period, we shall:

- Continue to pay for Covered Services during the first month of the Grace Period.
- Hold processing of non-Prescription Drug Claims for Covered Services provided during the second and third months of the Grace Period, or reserve the right to recover any amounts we may pay during this period.
- Reject Prescription Drug Services rendered during the second and third months of Grace Period.
- Notify Network Providers of the possibility for denied Claims during the second and third months of the Grace Period.

If you are not receiving APTC at the time you enter the Grace Period, your Grace Period will be thirty-one (31) consecutive calendar days following the due date of your unpaid Premium. During this period, we shall:

- Hold processing of non-Prescription Drug Claims for Covered Services provided during the Grace Period or reserve the right to recover any amounts we may pay during this period.
- Reject Prescription Drug Services rendered during the Grace Period.
- Notify Network Providers of the possibility for denied Claims during the Grace Period.

There are two ways for the Grace Period to come to an end:

- Paying the Premium amount due in full before the Grace Period expires. When this occurs:
    - We will process all non-Prescription Drug Claims that were held;
    - We will notify Network Providers and the United States Department of Health and Human Services, where appropriate, that you are no longer in the Grace Period;
    - We recommend you contact your Pharmacy to have your Prescription Drug Claims reprocessed.
- Expiration of the Grace Period without paying the Premium amount due in full. When this occurs:
    - We will terminate your coverage back to the end of the first month of the Grace Period if you are receiving APTC and to the end of the last month paid for those not receiving APTC.
    - We will deny any claims held during the Grace Period;
    - We will notify Network Providers and the United States Department of Health and Human Services, where appropriate, that you are no longer in the Grace Period;
    - See Section 12: *When Coverage Ends* for further details.

If you have not Effectuated your coverage, 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 Section 2: *Definitions*). 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 receive 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 most Covered Services. For a complete definition of Annual Out-of-Pocket Maximum, see Section 2*: Definitions*. 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
Adult Vision Benefits, if applicable	No

If You Receive a Bill

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.

Note: Please refer to Section 3: *How the Plan Works, Services Provided by Non-Network 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 2: *Definitions*. Not all Health Care Services will be covered by the Plan.

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 of 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, 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 scheduling an appointment or seeing your PCP or any Network Provider, please call Member Services.

Changing Your PCP

We hope you are happy with the PCP you have chosen, but 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 3: How the Plan Works, Continuity of Care* for more information on how to obtain Covered Services from Providers who leave the Network.

If You Can Not 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, 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 need 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 our 24-Hour Nurse Advice Line after or before Business Hours.

Canceling Provider Appointments

If you have to cancel an appointment with your PCP or any Provider, do so as far in advance of your appointment as possible. Providers may charge you for missed appointments. The Plan does 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.

Providers Who Leave the Network

If your PCP or a Provider who you see on a Regular Basis tells us that he or she is moving away, retiring, or leaving the Network for any reason, we will do our best to notify you in writing at least

thirty (30) calendar days before your PCP or Provider who you see on a Regular Basis leaves the Network.

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, the Plan, when appropriate, 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

We will continue to pay for Covered Services you receive from your PCP, for sixty (60) calendar days after the date your PCP leaves the Network, unless your PCP was terminated from our Network for reasons related to Fraud or quality of care.

If your PCP or Provider was removed from the Network without cause, then we may authorize continuing coverage with that PCP or Provider under circumstances including, but not limited to, undergoing a course of treatment for a serious and complex condition from the Provider or Facility, you're currently Inpatient, or you are scheduled to undergo nonelective surgery from the Provider, including receipt of postoperative care from such Provider or Facility with respect to a surgery. 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. Your Provider should contact the Utilization Management Department to obtain our Prior Authorization. The Plan will pay for such Benefits as if the PCP or Provider is in-Network, and the Plan 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 the Plan may not authorize continuing coverage with that PCP or Provider. Your PCP or Provider should contact the Utilization Management Department to obtain our Prior Authorization.

If you are pregnant 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, with our Prior Authorization, continue to receive Covered Services from that Provider through the delivery of your child and through the postpartum period. Please have your Provider contact the Utilization Management 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 Utilization Management Department to obtain our Prior Authorization.

If you have a chronic illness or condition that is life-threatening, degenerative, potentially

disabling, or congenital and requires specialized medical care over a prolonged period of time, you may, with our Authorization, continue to receive coverage for Covered Services by that Provider until you no longer need Health Care Services. Please have your Provider contact the Utilization Management Department to obtain our Prior Authorization.

If you are undergoing a course of institutional or Inpatient care from the Provider or Facility; or scheduled to have non-elective surgery from the Provider, including postoperative care from such Provider or Facility with respect to such a surgery, you may with our Authorization, continue to receive coverage for Covered Services provided by that Provider or Facility. Please have your Provider contact the Utilization Management Department to obtain our Prior Authorization.

Note: Please reference Section 12: *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:

- 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.
- Through the postpartum period if you are a new Covered Person and pregnant.
- 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 the Plan pays 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 the Plan with necessary medical information related to the care provided; and
- Comply with the Plan's 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.

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. It is the responsibility of your Network Provider to obtain Prior Authorization. If you receive Health Care Services from a Non-Network Provider, you or the Non-Network Provider are 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 1-833-230-2099 or by viewing it on our website at CareSource.com/mp-IN-pa. The Prior Authorization list is subject to change. Your Network Provider and you will be provided forty-five (45) calendar days prior notice before a change is made to the Prior Authorization list.

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 the Plan nor you will be required to pay for such Health Care Services. For Health Care Services provided by a Non-Network Provider, if Prior Authorization is not obtained by you or the Non-Network Provider, 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.

If we, or a utilization review organization acting on our behalf, issue a Prior Authorization for Health Care Services to be rendered by a Network Provider, and it was determined by the Network Provider that additional Medically Necessary Health Care Services that were not prior authorized were needed at the time the prior authorized Health Care Services were being rendered, we will not deny the Claim solely based on the lack of a Prior Authorization if such additional Medically Necessary Health Care Services were not anticipated at the time of the original Prior Authorization request and are Covered Services. However, CareSource may require a retrospective review of such Health Care Services and may withhold payment for such Health Care Services.

Benefit Determinations

In processing Claims, we review requests to determine whether the requested Health Care Services 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 1-833-230-2099.

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 should 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 use 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 and Retrospective Review:

Urgent Review- A request for review of any adverse decision of a Prior Authorization determination urgent health care services which means a health care service in which the application of the time periods for making non-urgent care determinations: could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, subject the Member to severe pain that cannot be adequately managed without the urgent health care service. In addition, a request involving urgent care also includes any request that a Physician with knowledge of the member's condition determines is a request involving urgent care.

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

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

Retrospective Review - 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 1-833-230-2099 with any questions you may have.

Review Request Category	Timeframe for Making Decision
Concurrent Care Reviews	Initial Inpatient Reviews – Within three (3) calendar days of our receipt of all necessary information to support your request. For concurrent stay reviews – Within forty-eight (48) hours of our receipt for continued stay requests. .
Urgent Care Reviews	Within twenty-four (24) hours from the receipt of request.
Preservice Care Reviews	Within forty-eight (48) hours from the receipt of the request.
Retrospective Care Reviews	Two (2) Business Days after receipt of request that includes all necessary information.

Notification of 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. 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.

SECTION 4 – 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 important for you to know certain information about your Benefits for Emergency Health Care Services, Urgent Care Services, Inpatient Services, and Maternity Services. This section explains those Benefits.

Emergency Medical Services

Emergency Medical 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 Medical 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 the 24-Hour Nurse Advice Line. Your PCP or the 24-Hour Nurse Advice Line can talk to you about your medical problem and give you advice on what you should do.

Remember, if you need Emergency Medical 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 for Observation or Inpatient level of care for post stabilization of your emergency medical condition, prior Authorization is not required. CareSource Members that receive Emergency Services for an Emergency Medical Condition will only be financially responsible for in-network cost-sharing amounts as a result of the care.

Notice to Your PCP or CareSource Following Emergency Care

If you receive Emergency Medical 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 and 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.

Emergency Medical Services Received from Non-Network Providers

If you received Emergency Medical Services and/or Emergency Ambulance Services from a Non-Network Provider, the services do not require Prior Authorization and will be considered Covered Services. Any applicable Copayment, Coinsurance, Annual Deductible, and/or Annual Out-of-Pocket Maximum requirements will be the same as if you obtained the Emergency Medical Services and/or Emergency Ambulance Services from a Network Provider. Non-Network Providers who render Emergency Medical Services to you should not send you a bill. 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 Medical 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 the 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, the Plan 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 and CareSource 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, the Plan 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. CareSource will comply with statutory requirements outlined within the No Surprises Act regarding any Covered Services received by you from Non-Network Providers.

How Benefits are Paid

Benefits provided pursuant to this section are payable at the Network level and are limited to the Maximum Allowable Amount. Our coverage is subject to your Coinsurance, Copayment, or Deductible. You may be responsible for any amount in excess of the Maximum Allowable Amount.

SECTION 5 – YOUR COVERED SERVICES

This section includes information on:

- Your Schedule of Benefits, which may be accessed by visiting CareSource.com/in/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 a part of this EOC. 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 3: *How the Plan Works, Prior Authorization.* Visit CareSource Indiana's website at caresource.com to review the Prior Authorization list or contact Member Services.

Several Covered Services have Benefit limits which are a maximum number of times that you are able to receive the service usually expressed in terms of visits or days. Unless otherwise stated, Benefit limits are for the entire Benefit Year. See Section 7: *What is Not Covered* for additional detail.

1. AMBULANCE SERVICES

The Plan provides Benefits for Emergency Ambulance Services by an emergency medical responder, an emergency medical technician, and advanced emergency medical technician, or a paramedic may transport a Member to: a health care facility, a mental health facility, or an urgent care facility that can provide the Member with appropriate and necessary treatment.

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 if you are subsequently transported to a Facility.

Limitations

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

Non-Covered Services include trips to a Physician's office, clinic, morgue, or funeral home.

2. AUTISM SPECTRUM DISORDER SERVICES

Description

The Plan provides Benefits for Covered Persons to diagnose and treat Autism Spectrum Disorders. Covered Services include Medically Necessary evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

Benefit	Benefit Limit
Inpatient Services	None
Diagnostic Evaluation	None
Screening, Testing, and Assessments	None
Outpatient Services	
Adaptive Behavior Treatment, including Applied Behavioral Analysis (ABA)	None
Physical Therapy	Included in Habilitative Benefits
Speech Therapy	Included in Habilitative Benefits
Occupational Therapy	Included in Habilitative Benefits
Psychotherapy	None
Medication Management	None
Crisis Intervention	None
Partial Hospitalization Program (PHP) Services	None
Intensive Outpatient (IOP) Services	None

Outpatient Physical Rehabilitation Services including:

- Speech Therapy or Occupational Therapy performed by a licensed therapist; and
- Clinical therapeutic intervention; defined as therapies supported by empirical evidence; which include but are 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.

Behavioral Health Care Services performed by an appropriate licensed or credentialed Behavioral Health Care Service Provider to provide consultation assessment, development and oversight of treatment plans.

Adaptive Behavioral Treatment; including Applied Behavioral Analysis; will be provided as prescribed 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.

3. BEHAVIORAL HEALTH CARE SERVICES

Description

The Plan provides Benefits for Behavioral Health Care Services (mental health and Substance Use Disorder) as described below. 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. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

Inpatient Stays. The Plan provides Benefits for Behavioral Health Care Services you receive during an Inpatient admission or confinement for acute inpatient services for mental health and substance use disorder services provided in a Hospital or other health care treatment Facilities providing acute Inpatient services. These services include Inpatient psychiatric hospitalization; inpatient detoxification treatment; and emergency evaluation and stabilization.

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, Medication Assisted Treatment, ambulatory or subacute detoxification, and pharmacological therapy in a congregate living community with 24-hour support.

Partial Hospitalization. The Plan provides Benefits for Behavioral Health Care Services you receive at an outpatient Partial Hospitalization Program (PHP). PHP is a treatment service for Behavioral Health Disorders with a treatment period of less than twenty-four (24) hours care in which the patient is assisted with issues related to the individual's reintegration into society. Partial hospitalization Items and services that can be included as part of the structured, multimodal active treatment program include:

- Individual or group psychotherapy with physicians, psychologists, or other behavioral health professionals authorized or licensed by the State in which they practice;
- Family counseling services for which the primary purpose is the treatment of the patient's condition; Patient training and education, to the extent the training and educational activities are closely and clearly related to the individuals care and treatment of his/her diagnosed behavioral health condition;
- Medically necessary diagnostic services related to behavioral health treatment.

Intensive Outpatient Services. The Plan provides Benefits for Health Care Services you receive during an outpatient Intensive Outpatient Program (IOP). IOP Services are mental health and/or Substance Use Disorder "SUD" treatments provided in an outpatient setting. Generally, IOP Services include three (3) hours of treatment per day, and the program is available at least two (2) to three (3) days per week. The services may address mental health and/or substance use disorder issues. These programs are usually used as a step down from acute inpatient care, residential care, or a partial hospitalization program. They may also be viewed as a step up from regular outpatient services.

Opioid Treatment Program. The Plan provides Benefits for Behavioral Health Care Services rendered in an Opioid Treatment Program (OTP) setting by an appropriately certified OTP. These Health Care Services can include medication assisted treatment, diagnostic evaluation, individual and group psychotherapy, and toxicology testing.

Outpatient Services. The Plan provides Benefits for office-based Behavioral Health Care Services. These include diagnostic evaluation, psychological testing, individual, group, and family.

Benefit	Benefit Limit
Inpatient Services	None
Residential Treatment Services	None
Outpatient Services	
Diagnostic Evaluation	None
Screening, Testing, and Assessments	None
Individual Psychotherapy	None
Group Psychotherapy	None
Family Psychotherapy	None
Medication Management; including Medication Assisted Treatment (MAT) for Substance Use Disorder Treatment	None
Crisis Service	None
Other Outpatient Services	
Partial Hospitalization Program (PHP) Services	None
Intensive Outpatient Psychiatric (IOP) Services	None

Limitations

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.

4. CHIROPRACTIC CARE SERVICES

The Plan provides Benefits for Chiropractic Services to treat or diagnose conditions of the joints of the spine and nervous system. Services include but are not limited to office visits, Medically Necessary chiropractic therapy such as physical therapy and manipulation therapy. Benefit limits will apply based on the type of services rendered. Please see Section 5: *Your Covered Services, Rehabilitative Services – Outpatient Therapy* and Section 5: *Your Covered Services, Habilitative Services* for applicable limits, such as manipulation therapy and physical therapy. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

5. 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. Please see Section 2: *Definitions*, for what constitutes an approved Clinical Trial.

Limitations

The Plan does not cover the following:

- A Health Care Service that 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;
- A Health Care Service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- 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 the Plan, including the sponsor of the Clinical Trial.

6. DENTAL SERVICES - OTHER

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, the Plan may provide Benefits, at its discretion, even if there may be several years between the accidental Injury and the final repair. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

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.

Dental Anesthesia Services: The Plan also covers Dental Health Care Services for anesthesia and Hospital or Facility charges for services performed in a Hospital or Ambulatory Surgical Facility as indicated by the American Academy of Pediatric dentistry. These services must be in connection with dental procedures for Members with a physical or mental impairment that substantially limits one (1) or more major life activities of the individual and the admitting Physician or dentist must certify that, because of the physical or mental impairment, hospitalization or general anesthesia is

required in order to safely and effectively perform the procedures. Benefits are not provided for routine dental care.

Limitations

The provisions of this section may not be construed to require coverage for the dental care for which the services described within this subsection are provided.

Covered Services are limited to $3000 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.

7. DIABETES 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." Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

Limitations

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

8. DIAGNOSTIC SERVICES

Description

The Plan provides Benefits for non-invasive Diagnostic Services, including but not limited to the following. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

- X-ray/radiology services, including mammograms for any person diagnosed with breast disease;
- Laboratory and pathology services, including allergy testing and bone density testing as determined Medically Necessary;
- Biomarker testing as determined Medically Necessary, supported by medical and scientific evidence including: (1) labeled indications for a test approved or cleared by the United States Food and Drug Administration (FDA); (2) indicated tests for a drug approved by the FDA; (3) a warning or precaution on the label of a drug approved by the FDA; (4) a national coverage determination of the Centers for Medicare and Medicaid Services (CMS); (5) a local coverage determination of a Medicare administrative

contractor; or (6) nationally recognized clinical practice guidelines or consensus statements.

- Advanced Imaging such as: MRI, MRA, PET, SPECT, and CT imaging procedures;
- Cardiographic, encephalographic, and radioisotope tests.

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

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.

9. EMERGENCY HEALTH CARE SERVICES

Description

The Plan provides Benefits for Emergency Health Care Services to treat an Emergency Medical Condition. Benefits for Emergency Health Care Services include Health Care Services needed to evaluate, Stabilize, or treat an Emergency Medical Condition. Coverage for services provided to Stabilize an Emergency Medical Condition are covered regardless of the hospital department where services are provided. Coverage for Emergency Services includes those provided in Hospitals and independent freestanding emergency departments. 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. Please refer to the *Services Provided by Non-Network Providers* within Section 3: *How the Plan Works* and Section 4: *Important Information on Emergency, Urgent Care, and Inpatient Services* for further details.

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. Prior authorization is not required for post stabilization services provided following emergency care services. For continued Inpatient Stay services, Prior Authorization is required. 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.

10. HABILITATIVE SERVICES

Description

Habilitative Services are Health Care Services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other maintenance therapy services for people with disabilities in Outpatient settings.

Benefit	Benefit Limit
Physical Therapy	20 Visits
Occupational Therapy	20 Visits
Speech Therapy	20 Visits

Limitations

Benefits for Habilitative Services do not apply to those Health Care Services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training, and residential treatment are not Habilitative Services.

We may require that a treatment plan, medical records, clinical notes, or other necessary data be provided to us in order for us to substantiate that the Health Care Services are Medically Necessary and that the Covered Person's condition is clinically improving or staying the same as a result of the Habilitative Services. A treatment plan must include the diagnosis, the proposed treatment by type, the frequency, the anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated or assessed.

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:

- 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.

Limitations

The Plan provides Benefits for up to a maximum of one hundred (100) combined 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.

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. Benefits for Private Duty Nursing are limited separately to a maximum of one hundred (100) eight (8) hour visits per Benefit Year. One (1) visit equals eight (8) hours or less.

Non-Covered Services include:

- Food, housing, homemaker services and home delivered meals.
- Custodial Care.
- Maintenance Therapy.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges billed by the Home Health Care Agency.
- Helpful environmental materials (handrails, 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 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 twelve (12) months or less, as confirmed by your attending Physician. Hospice Benefits will continue if you live longer than twelve (12) 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.
- Bereavement (grief) services including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers, and sisters.

Limitations

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

- Medical equipment, supplies and equipment used to treat you when the Facility you are in should provide such equipment
- Services received if you do not have a Terminal Illness
- Services provided by volunteers.
- Housekeeping services.

13. INFERTILITY SERVICES

Description

The Benefit Plan covers services for the diagnosis and treatment of the underlying causes of infertility when provided by or under the direction of a Network Provider. Covered Services include Medically Necessary treatment and procedures that 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 7: *What Is Not Covered.*

14. INPATIENT SERVICES

Description

The Plan provides Benefits for Inpatient Services. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

- Charges from a Hospital or Skilled Nursing Facility (SNF) or other Provider as authorized by the Plan 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.

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, including outpatient Day Rehabilitation Therapy Services.

The following consultations are not Covered Services: staff consultations required by Hospital rules; consultations requested by you; routine radiological or cardiographic consultations; telephone consultations; and EKG transmittal by phone.

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. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

If you are pregnant when your Benefits begin, please refer to the Continuity of Care for New Covered Persons provisions in Section 3: *How the Plan Works*. These provisions describe how the Plan provides coverage for Non-Network Providers if you are pregnant.

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 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 including but not limited to clinical tests for the detection of the following: (i) phenylketonuria; (ii) hypothyroidism; (iii) hemoglobinopathies, including sickle cell anemia; (iv) galactosemia; (v) Maple Syrup urine disease; (vi) homocystinuria; (vii) inborn errors of metabolism that results in intellectual disability and that are designated by the state department; (viii) congenital adrenal hyperplasia: (ix) biotinidase deficiency; (x) disorders by tandem mass spectrometry or other technologies with the same or greater detection capabilities as determined by the state; (xi) HIV or the antigen to HIV; (xii) spinal muscular atrophy; or (xiii) severe combined immunodeficiency; (xiv) Krabbe disease; (xv) Pompe disease; (xvi) Hurler syndrome; and (xvii) adrenoleukodystrophy. Covered Services for follow-up care also include, 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, such as a newborn hearing screening. 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

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

A. Repairs or Replacements

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.

B. Medical Supplies

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.
- 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.
- Syringes, needles, oxygen, surgical dressings, splints, and other similar items which serve only a medical purpose.
- Diabetic testing supplies. A limited list of diabetic testing supplies is covered on the Prescription Drug Formulary.
- Clinitest.
- 100% human diet, if the 100% human diet and supplemented milk fortifier products are prescribed for the prevention of necrotizing enterocolitis and associated co-morbidities and administered under the direction of a physician. 100% human diet means the supplementation of a mother's expressed breast milk or donor milk with a milk fortifier.
- 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.
- Contraceptive devices including, but not limited to diaphragms, intrauterine devices (IUDs), and implants.

Limitations

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.
- Med injectors.

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

C. Durable Medical Equipment

The Plan provides Benefits for certain Durable Medical Equipment, as described in this section. 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
- Wearable cardioverter defibrillators, necessary accessories, and ongoing monitoring services
- Augmentative communication devices are covered when we approve based on your condition
- Wheelchairs
- Hospital beds
- Oxygen equipment
- CPAP machines when indicated for sleep apnea

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

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

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.

D. 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. As required by state law, this coverage includes one (1) custom fabricated breast prostheses and one (1) additional breast prosthesis per breast affected by a mastectomy.
- 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.

Benefits for an artificial leg or arm will equal the standards for the federal Medicare program unless a different reimbursement rate is negotiated.

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 5.
- 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.

E. Orthotics

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).

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 as determined by the Plan. These Facilities may include a non-Hospital site providing Diagnostic Services, therapy services, surgery, other therapy services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation), or other Provider Facility as determined by us.

Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

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. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

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.

Telehealth Services see Section 5: *Your Covered Services, Telehealth 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 5: *Your Covered Services, Habilitative Services and Rehabilitative Services* for more information.

19. PRESCRIPTION DRUGS

Please refer to Section 6: *Prescription Drugs* for information on your Prescription Drug coverage.

20. PREVENTIVE HEALTH CARE SERVICES

The Plan provides Benefits for Preventive Health Care Services, including voluntary family planning 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. You may call Member Services for additional information about these services.

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.
  - Screening for diabetes in pregnancy.

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

- Breast cancer screening mammography coverage provided by CareSource is equal to or greater than that which is required by state and federal law. Diagnostic breast cancer

screening mammography including: (a) one (1) baseline breast cancer screening mammography for a Covered Person between thirty-five (35) and forty (40) years of age, (b) one (1) baseline screening mammography performed each year for a Covered Person who is less than forty (40) years of age and determined to be high risk, (c) any additional mammography views that are required for proper evaluation, and (d) ultrasound services, if determined to be Medically Necessary. A woman is considered to be high risk if she meets at least one of the following criteria:

- Has a personal history of breast cancer;
- Has a personal history of breast disease proven benign by biopsy;
- Has a mother, sister, or daughter who has had breast cancer; or
- Is at least thirty (30) years of age and has not given birth.

- Diagnostic colorectal cancer screenings. Examinations and laboratory tests for colorectal cancer for a non-symptomatic Covered Person who (i) is either at least forty-five (45) years of age, or (ii) is under the age of forty-five (45) years and is at risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society. Colorectal cancer screening means examinations and laboratory test for cancer for any non-symptomatic Covered Person.
- Diagnostic prostate cancer screening. One prostate specific antigen test is covered annually for a Covered Person who either is at least fifty (50) years of age or who is less than fifty (50) years of age and at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.
- Routine hearing screenings. See Section 5: *Your Covered Services, Routine Hearing Services, Hearing Aids, and Related Services* for more information. For newborn hearing screening, see Section 5: *Your Covered Services, Maternity Services*.
- Sports physicals for children who are in elementary school through high school.
- Voluntary family planning services.

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.

21. 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 and chest wall reconstruction with aesthetic flat closure resulting from a mastectomy as required by the Women's Health and Cancer Rights Act and state law. See Section 13 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.
- Cleft palate.

22. REHABILITATIVE SERVICES - THERAPY

Description

The Plan provides Benefits for certain therapy services if given as part of Physician Home Visits and Office Services or Outpatient 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.

Benefit	Benefit Limit
*Physical Therapy**	20 Visits
*Occupational Therapy**	20 Visits
*Speech Therapy**	20 Visits
Manipulation Therapy	12 Visits
Physical Medicine and Rehabilitation Services including Day Rehabilitation	60 Visits
*Cardiac Rehabilitation Therapy**	36 Visits
*Pulmonary Rehabilitation Therapy**	20 Visits
Chemotherapy	None
Dialysis	None
Radiation Therapy	None
Inhalation Therapy	None

*When rendered in the home, Home Health Care Services limits apply.

Physical 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.

The Plan does not provide Benefits for physical therapy services that are for maintenance therapy, except when such physical therapy is an Habilitative Service; 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

The Plan will provide Benefits for occupational therapy for treatment if you are physically disabled 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.

The Plan does not provide Benefits for occupational 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 correction of a speech impairment.

Manipulation Therapy

The Plan will provide Benefits for 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.

The Plan does not provide Benefits for manipulation therapy services provided in the home as part of Home Health Care Services.

Physical Medicine and Rehabilitation Services

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.

Covered Services include 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. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to, admissions to a Hospital mainly for physical therapy and long term rehabilitation in an Inpatient setting.

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 include a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **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 a Physician's office including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient Rehabilitation Facility setting is not a Covered Service. 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; non-pressurized 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.

23. ROUTINE HEARING SERVICES, HEARING AIDS, AND RELATED SERVICES

The Benefits available to you under this section are administered by TruHearing®. 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, you will be responsible for all costs and such Health Care Services will be considered Non-Covered Services.

Please call 1-866-202-2561 for help locating a TruHearing Network Provider and for additional information and details.

The Plan provides Benefits for the following routine hearing services:

- Routine Hearing Screening: One (1) screening per Benefit Year Covered in Full which 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. For newborn hearing screening, see Section 5: *Your Covered Services, Maternity Services*.
- Routine Hearing Exam: One (1) exam per Benefit Year Covered in Full which includes 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 Discount Program. The TruHearing Choice Discount 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 Discount 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 Discount Program will be responsible for 100% of the hearing aid costs.

- 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 surgical sterilization procedures and related services received in a Physician's office or on an Outpatient basis at a Hospital or Alternate Facility.

Reversals of sterilization are not Covered Services. 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.

26. TELEHEALTH 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. Telehealth Services may be received from your PCP, other Network Provider, or through Teladoc.

You should consider Telehealth 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 or behavioral health Provider is not available.

See your member handbook or call Member Services for further details on how to schedule telehealth visits.

Telehealth Services are available through Teladoc which can be accessed on caresource.com/in/members/tools-resources/where-to-get-care/marketplace/ or by calling Member Services.

CareSource fully supports Telehealth Services through all Network Providers, including for specialty services potentially not available through Teladoc. Services received may be subject to cost share which would be outlined in your Schedule of Benefits for the services rendered but will never be less favorable than the cost shares that apply to the comparable services delivered in person.

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
- Physician to Physician consultation

27. TEMPOROMANDIBULAR OR CRANIOMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR JAW DISORDER

Description

The Plan provides Benefits for any jaw joint problem, including temporomandibular joint disorder, cranio-maxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jawbone and the skull. The benefits are limited to the following:

- An examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation as necessary.
- Diagnostic x-rays.
- Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service.
- Diagnostic therapeutic masticatory muscle and temporomandibular joint injections.
- Appliance therapy utilizing an appliance which does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the maximum allowable fee for use of a single appliance, regardless of the number of appliances used in treatment. The Benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance.
- Surgical procedures

Limitations

- Expenses covered under this benefit are not covered under any other section of this EOC
- Does not include coverage for
    - Occlusal analysis or
    - Any irreversible procedure, including but not limited to orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures or full dentures.

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

Description

Covered Blood Services

Your Benefits cover the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a Members own blood only when it is stored and used for a previously scheduled procedure.

Covered Transplant Procedure

The Plan provides Benefits for human organ and stem cell/bone marrow transplants and transfusions 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.

- Cornea and kidneytransplants are covered as Surgical Services and the transplant benefits outlined below do not apply.
- 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 Period. 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.

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.

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. These charges will NOT apply to your Out- of-Pocket Limit.

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 reimbursement up to a maximum of Ten Thousand Dollars ($10,000) for certain Benefits associated with your reasonable and necessary travel expenses as determined by us 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, 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.

Non-Covered Services for transportation and lodging include:

- Childcare;
- 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.

Donor Location Costs

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 procedure.

Authorization Requirements

Your Provider must call our Utilization Management Department so that we can provide Prior Authorization for a transplant procedure, including any live donor, transportation and lodging, or donor location costs. 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.

29. 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 Visit and Office Services* earlier in this section.

30. 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 provide 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, 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.

The definition below is 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, monocular and binocular visual acuity, with or without present corrective lenses; neurological integrity (pupil response); biomicroscopy (external exam); visual field testing (confrontation); ophthalmoscopy (internal exam); tonometry (intraocular pressure); refraction (with recorded visual acuity); extraocular muscle balance assessment; dilation as required; present prescription analysis; specific recommendation; assessment plan; and Provider signature.

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:** Covered in Full, limited to one (1) per Benefit Year. Includes dilation, if Medically Necessary.
    - **Standard Contact Lens Fit and Follow-Up**: Cost share applies, limited to one (1) per Benefit Year.
    - **Premium Contact Lens Fit and Follow-Up**: You are responsible for the cost of the exam less 10% discount. Limited to one (1) per Benefit Year.
- **Eyewear: You may choose prescription glasses or contacts.** The Plan also provides Benefits for one (1) replacement pair of eyeglasses every Benefit Year if it is Medically Necessary, and subject to limitations and Exclusions outlined in this EOC.
    - **Frame and Frame Fitting:** Covered in Full including provider designated frames. Limited to once per Benefit Year.
    - **Lenses:** Limited to one pair of lenses per Benefit Year.
        - Lens Options:
            - 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
- Photochromatic / transitions plastic - $0 Copay
- Anti-reflective coating
  - Standard - $45
  - Premium tier 1 - $57
  - Premium tier 2 - $68
  - 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:** Covered in Full once every Benefit Year – in lieu of eyeglasses. Includes the following options:
    - Conventional contact lenses: one (1) pair
    - Daily Wear / Disposable: Up to three (3) months' supply of daily disposable, single vision spherical
    - Extended Wear Disposables: Up to six (6) months' supply of monthly or two (2) week disposable, single vision spherical or toric contact lenses

- **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 (1) 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 (1) per Benefit Year.
- **Retinal Imaging Benefit:** Covered at no member cost share. Limited to one (1) per Benefit Year.
- **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, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

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

Additional services

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

- 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.
- Additional Pairs Discount: The Plan will only provide Benefits for one eyewear allowance for eyeglasses 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 at the point of sale with a Network Provider. Not all Providers honor discounts on Non-Covered Services.
- Lens Add-Ons: Members receive a 20% discount off Retail Price for lens options not listed above.

Limitations

We do not cover the following:

- Services provided by providers not within the EyeMed 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;
- Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion, or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
- State or territorial taxes on vision 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 6 – PRESCRIPTION DRUGS

What this section includes answers to:

- What is my Prescription Drug Benefit?
- How do I use my Prescription Drug Benefit?
- How does my Prescription Drug Benefit work?
- What is not Covered by my Prescription Drug Benefit?

What Is My Prescription Drug Benefit?

Your Prescription Drug Benefit is the part of your plan that pays for prescriptions you fill at a pharmacy. Usually, you will use your Prescription Drug Benefit to fill prescriptions for drugs. You might also use it to fill prescriptions for devices like blood glucose monitors or testing strips. You may have drugs that your healthcare Provider gives to you at your Provider's office or somewhere like an infusion center. When you take a take a drug that has to be given to you by a healthcare professional, it is often paid for under your Medical Benefit. This section will help you learn how to use your Prescription Drug Benefit, how it works, and what your responsibility is when you use it.

This section will talk about your Prescription Drug Formulary (or just Formulary). Your Formulary is a list of cost-effective drugs that you might use. Usually, drugs and devices on the Formulary are covered for you, but sometimes limits apply. We will talk about limits more below. Your Prescription Drug Benefit may also cover drugs that are not on the Formulary (called non-Formulary drugs). We will tell you how you or your provider can ask for non-Formulary drugs in the sections below too.

How Do I Use My Prescription Drug Benefit?

To use your Prescription Drug Benefit, show your ID card to the pharmacy every time you fill a prescription. The pharmacy will use the information on your ID card to bill your plan. The pharmacy will tell you how much your prescription costs after they have billed your plan. This cost may include your Copayment, Coinsurance, and/or Deductible. You will need to pay for your drug when you fill the prescription.

If you do not show your ID card to the pharmacy when you fill a prescription, you may have to pay the full cost of the drug. Ask your pharmacist for an itemized receipt. You can complete a form and send it to our Pharmacy Benefit Manager (PBM). This is called submitting a direct Claim for reimbursement. Our PBM will be able to process the Claim, apply allowed costs toward your Deductible and Annual Out-of-Pocket Maximum, and send you a refund if you are owed one. You may not get a refund if:

- The drug is not covered by your plan,
- The pharmacy is not a Network Pharmacy, or
- The amount you paid was less than your Copayment, Coinsurance, and/or Deductible.

You must submit a direct Claim within twelve (12) months of paying for your prescription. Your final cost may be higher when you submit a direct Claim.

Pharmacy Network

Your Prescription Drug Benefit only covers prescriptions that are filled at a Network Pharmacy. If you fill a prescription at a pharmacy that is not a Network Pharmacy, you will have to pay for the full cost of the drug. You can search for Network Pharmacies on our website. Our Member Services team can also help you find a Network Pharmacy when you call them at the number on your ID card.

Some prescriptions have to be filled at a specialty pharmacy. We will talk more about these drugs below. You or your provider must order these drugs directly from a Network specialty Pharmacy.

You can also get your prescriptions filled by a mail order pharmacy. The mail order pharmacy will fill your prescriptions and send them right to your home. The mail order pharmacy is managed by our PBM. You can find more information about how to enroll on the Mail Order Drugs page on CareSource.com or by calling our PBM at 1-888-848-4452.

Sometimes drug manufacturers only make their drugs available through certain pharmacies. This is known as Limited Distribution. If your provider prescribes a Limited Distribution drug for you, you may have to go to a different pharmacy than usual to fill your prescription. We will work with you and your provider to help you find the right pharmacy to dispense the drug.

Prescriptions for Eye Drops

Please note the timelines below if your provider prescribes eye drops for you, and the prescription states that refills are needed. If your prescription is for a 30-day supply, you can refill it between 25-30 days after either the date you received the prescription or the date of your last refill (whichever was later). If your prescription is for a 90-day supply, you can refill it between 80-90 days after either the date you received the prescription or the date of your last refill (whichever was later). If your prescription states that an additional bottle is needed for use in a day care center or school, your plan will also cover one (1) additional bottle.

If you have questions or concerns about refilling your eye drops, please reach out to your pharmacy or call Member Services at the number on your ID card.

How Does My Prescription Drug Benefit Work?

Your Prescription Drug Benefit works differently than your Medical Benefit. When you use your Prescription Drug Benefit to fill a prescription, the pharmacy will usually be able to tell you right away if the drug or device is covered, if any extra limits apply, and how much you will have to pay.

Your Prescription Drug Benefit only covers drugs and devices that are Medically Necessary. We will cover Medically Necessary drugs and devices that are used for purposes that have been approved by the U.S. Food and Drug Administration (FDA). We might also cover drugs and devices for uses that have not been approved by the FDA (off-label uses) if standard medical literature supports the use as both safe and effective. Both state and federal laws define what counts as standard medical literature.

Your Prescription Drug Formulary

Before going to your Provider’s office or the Pharmacy to fill your prescription, you can look at the Prescription Drug Formulary (or just Formulary) to see if the drug is covered. The Formulary

is available online at CareSource.com/Marketplace. We also have a search tool on our website where you can search for drugs. We can send you a printed copy of the Formulary if you call Member Services to ask for one; the phone number is listed on your ID card.

If a drug or device is on the Formulary, it is usually covered by your plan. Some drugs or devices on the Formulary have extra limits on them. Here are some of the limits you may see:

- **Prior Authorization (PA).** On your Formulary, Prior Authorization limits will show as "PA." If a drug has a Prior Authorization limit, we need more information before the drug will be covered for you. Your Provider will need to give us this information electronically or fax it to us. The forms they can use are on our website. The information we need might be about your medical history, drugs you have tried before, or certain tests that your Provider may have ordered for you. We will ask for this information to help make sure that the drug is Medically Necessary for you. Your Provider can see all of the information we will ask for by using the Formulary Search Tool on the Provider's page of our website.
- **Step Therapy (ST).** On your Formulary, Step Therapy limits will show as "ST." If a drug has a Step Therapy limit, you will need to try another drug first. We will ask you to try another drug first if the drug is cheaper and works just as well for most people. You and your Provider may decide that the cheaper drug is not a good fit for you. Your Provider can ask to bypass the limit by sending a request electronically or by faxing it to us. Your plan will not cover the drug with the Step Therapy limit until you have tried the cheaper drug, or we have approved a request to bypass the limit.
- **Quantity Limit.** On your Formulary, Quantity Limits will show as "QL." A Quantity Limit will usually limit how much of the drug you can get at a time. It may also set a limit for how much of the drug you can get over a timeframe like a month or a year. We will put a Quantity Limit on a drug to make sure it is being used at doses that the Federal Food and Drug Administration (FDA) has approved. Quantity Limits also help to make sure your prescriptions cost as little as possible for both you and your plan. If you or your Provider think you need a higher amount, your Provider can ask to bypass the limit by sending a request electronically or by faxing it to us. Your plan will not cover a higher amount until we have approved a request for it.
- **Age Limit.** On your Formulary, Age Limits will show as "AL." An Age Limit will stop a drug from being covered if you are over or under a certain age. We may put an Age Limit on a drug if a drug is not approved by the FDA for some ages or if a dosage form is not the best choice for some ages. For example, we will usually require adults to take pills and allow children to take liquid drugs if both are available. If you or your Provider think you need a drug outside of the Age Limit, your Provider can ask to bypass the limit by sending a request electronically or by faxing it to us. Your plan will not cover a drug outside the Age Limit until we have approved a request for it.

Remember that you or your Provider can submit a request to bypass any of the limits listed above. If we deny one of these requests, you may request an appeal (see Section 9: *Grievance Process and Adverse Benefit Determination Appeals.*)

An approved request is not a guarantee that we will provide Benefits for the drug that you or your Provider requested. In order for us to provide these Benefits:

- You must be eligible for coverage under the Plan,

- The drug/product must be a Covered Service, and
- The drug/product may not be subject to an Exclusion under the Plan.

Please see What Is Not Covered by My Prescription Drug Benefit to learn more about what drugs and products are not covered by your Prescription Drug Benefit (subject to an Exclusion).

The Formulary is organized in levels called tiers. Your plan has five tiers:

- **Tier 0** includes drugs that are considered preventive by certain laws like the Affordable Care Act. You might take these drugs to prevent a health issue instead of treating it after it has happened. You will not have to pay a Copayment or Coinsurance for drugs in tier 0.
- **Tier 1** includes low-cost prescription drugs like generics. Your Copayment or Coinsurance will be the lowest for drugs in this tier.
- **Tier 2** includes drugs that have a higher Copayment or Coinsurance than drugs in tier 1. These drugs will be brand name drugs that your plan prefers. You may see us call these "preferred brand name drugs."
- **Tier 3** includes drugs that have a higher Copayment or Coinsurance than drugs in tier 2. These drugs will be brand name drugs that your plan does not prefer. You may see us call these "non-preferred brand name drugs." Often, drugs in tier 3 may not be covered until you have tried certain drugs from tier 1 or tier 2. This would be an example of a Step Therapy limit.
- **Tier 4** includes drugs that are considered specialty drugs. A specialty drug is usually one that has extra safety monitoring or storage requirements or a drug that must be given in a specific way. Prescriptions for specialty drugs have to be filled by a specialty pharmacy that can handle the extra requirements. Specialty drugs are also usually the most expensive. Drugs in this tier have a higher Copayment or Coinsurance than those in tier 3, and they may be either brand name or generic drugs.

Depending on your plan, your Deductible may apply to drugs in some tiers but not others. Your Schedule of Benefits will tell you the specific Copayment, Coinsurance, and Deductible details for your plan. Your Schedule of Benefits will also give you more details about how many days' worth of drugs you can get at a time and other similar limits.

Knowing what tier a drug is in is the most important way to know how much it will cost. Here are some other things to know about drug cost and your Prescription Drug Benefit:

- When you fill a prescription for a drug, you may pay less than your Copayment or Coinsurance if the cost of the drug for the pharmacy or the price that your plan and the pharmacy have agreed on is cheaper.
- Your cost is related to the days' supply of your prescription. You can usually fill for more than a one-month supply at a time through your mail order pharmacy. Your total cost share will be discounted for prescriptions filled through mail order pharmacy. Refer to your Schedule of Benefits to see additional details. For more information about filling your prescriptions through mail order, you can call Member Services at the number on your ID card or call the mail order pharmacy directly at 1-888-848-4452. Specialty drugs will be limited to a 30-day supply at a time.
- Brand name drugs may not be covered if a generic for the same drug is available. If it is

covered, it may cost you more than the generic would. Please note, for Brand-name Drugs that have an approved generic, you may be required to pay the difference between the cost of the brand and the generic, in addition to your cost-share of the drug.

- You may use a copay card to get a discount on a drug that your plan covers. Copay cards will cover some of the Copayment or Coinsurance you have after your plan has paid for the drug. Drug manufacturers usually offer copay cards for expensive Brand-name Drugs up to a certain savings amount or number of fills. Any portion of the cost of a Prescription Drug that is paid, waived, or reimbursed by a pharmaceutical manufacturer or related entity may not be credited to your Deductible, Coinsurance, or Maximum Out-of-Pocket limit unless required by state or federal law. **IMPORTANT NOTE:** If you are enrolled in a Health Savings Account (HSA) Eligible Plan and use a copay card before your Deductible has been met, your tax savings for the HSA Eligible Plan with the Internal Revenue Service may be jeopardized.
- When your plan approves a request to cover a non-Formulary drug, you will pay the highest Copayment or Coinsurance that applies to that drug. For example, if it is a brand name drug that is not a specialty drug, you will pay the Copayment or Coinsurance that applies to tier 3 drugs.
- You may be treating cancer with a drug that you can give to yourself orally, such as a pill or tablet. If so, the Copayment, Coinsurance, or Deductible that applies to the oral drug will not be more than the Copayment, Coinsurance, or Deductible that applies to a drug your provider would have to give you, such as an injection or infusion.

Your Formulary is an important part of your Prescription Drug Benefit because it shows what drugs may be covered for you, what limits may apply, and what tier drugs are in. A committee of healthcare providers, like doctors and pharmacists, decide what will be included on your Formulary. This is called the Pharmacy and Therapeutics (P&T) Committee. The P&T Committee also decides what information we will ask for when a drug has a Prior Authorization limit and what drugs we will ask you to try when a drug has a Step Therapy limit. The P&T Committee has the last word about your Formulary and all the limits and tiers we talk about above. Their job is to make sure your Formulary encourages you to use drugs that will be safe and effective for you.

The P&T Committee looks at your Formulary regularly to make sure it is up-to-date. We may change your Formulary based on the decisions of the P&T Committee. You can always find the most up-to-date Formulary by using the search tool on our website, or by calling Member Services to ask for a printed copy. If we make a change to your formulary that impacts a drug you are taking, we will send you a notice before the change takes effect. You or your Provider can request an exception to the change.

Drug Exception (Non-Formulary Drug) Process

If a drug, device, or contraceptive is not on the Formulary (covered by the Plan), CareSource has a process that allows you to request to gain access to clinically appropriate drugs not otherwise covered by the health plan, as required by federal law. This is called a drug exception (non-Formulary drug) process.

If a drug exception (non-Formulary drug) is granted, the drug (non-Formulary drug) will be treated as an Essential Health Benefit subject to all applicable Copayments, Coinsurance, and Annual Deductible requirements of your Plan. Your cost share of the drug (non-Formulary drug)

or contraceptive will count toward your Annual Out of Pocket Maximum.

You may submit a request for review of a non-formulary drug through the drug exception (non-Formulary) process by using the Member Exception Request Form on our website. With your consent, such requests may also be submitted on your behalf by your Authorized Representative or by the Provider who prescribed the drug (non-Formulary drug). We will provide you with written notification of its determination.

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

Timing of Prescription Drug Request Determinations

Type	Standard Request	Expedited (urgent) Request
Formulary	72 hours	24 hours
Non-Formulary	72 hours	24 hours

Next Level of Review for a Non-Formulary Drug Determination

If your request is denied, written notification will explain how you may request the next level of review of our exception review determination, which is an independent, external review as required by federal law.

External Review of Your Drug Exception (Non-Formulary Drug)

If we deny your request for a drug exception (non-Formulary drug), you or the Provider who prescribed such drug may request, either verbally or in writing, an independent review of our determination. With your consent, such request may also be submitted on your behalf by your Authorized Representative. The external review will be conducted by an independent review entity (IRE) contracted by us to review the exception request denial. You will be provided with notification of their determination within seventy-two (72) hours after your request was received. However, if the exception request was expedited, then you will receive verbal notification of their determination within twenty-four (24) hours after your request was received.

Request for External Review of a Drug Exception by Independent Review Entity (IRE)

You or your Authorized Representative, including your Provider, may request an External Review by sending it to CareSource Indiana Member Appeals, P.O. Box 1947, Dayton, OH 45401 or calling us at 1-833-230-2099.

Our Pharmacy Benefit Manager

We work with another company which helps us with your Prescription Drug Benefit. They are our Pharmacy Benefit Manager (PBM). They do things for you and your plan like:

- Give ideas to our P&T committee about what to put on the Formulary,
- Help pharmacies bill your plan for prescriptions that you fill,
- Give us tools to help you find information about your Formulary and drug costs,
- Help us get access to lower cost drug so that you pay less for your plan, and

- Give you access to a nationwide pharmacy network including a mail order pharmacy and a specialty drug pharmacy network.

The PBM helps us make sure that the right drugs are covered for you at the pharmacy and that you pay the right amount for them based on your Formulary. They also help your pharmacy check for things like drug interactions or drug doses that may not be safe. They can answer some questions that your pharmacy may have about billing a prescription. Sometimes, they may help us contact you or your provider about drugs that you take. We may also ask them to offer programs that help you take your drugs in the most safe and effective way.

The PBM helps us make sure that your Prescription Drug Benefit works correctly, but they do not make decisions about how it will work. They also may not make changes to your Benefit except when and how we tell them to. If you have questions about what the PBM does for you or your plan, please call Member Services at the number on your ID card.

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 free program 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.

Opioid Analgesics and Controlled Substances

Opioid analgesics are a type of drug that is usually prescribed to manage severe pain. They are controlled substances which means they are subject to special rules and restrictions at both the federal and state level. For example, state laws limit the amount, duration, quantity and the types of drugs or combinations of drugs that can be prescribed at a period of time. These limits help to keep you safe and help to prevent abuse or diversion of these drugs. If your provider writes a prescription for you for an opioid analgesic to treat chronic pain, it will require a Prior Authorization. Other controlled substances may require a Prior Authorization as well.

What Is Not Covered by My Prescription Drug Benefit?

Your plan does not cover everything. You can find more coverage exclusions in Section 7: *What Is Not Covered*, and that list also applies to your Prescription Drug Benefit.

When it comes to drugs, your plan will not cover:

- Drugs or devices that are not on the Prescription Drug Formulary and that do not meet all requirements for clinical appropriateness.
- Drugs or devices that are not approved by the U.S. Food and Drug Administration (FDA).

- Drugs or devices that have been dispensed to you with a date of service outside of your coverage eligibility.
- Drugs or devices that are 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.
- Drugs or devices 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.
- Drugs or devices that are covered under your Medical Benefit (see Section 5: *Your Covered Services*).
- Drugs or devices that are available over-the-counter (OTC) and do not require a prescription order or refill by law before being dispensed unless:
    - The plan has designated the OTC drug or device as eligible for coverage as if it were a prescription drug, or the OTC drug or device is classified as a Preventive Health Care Service, AND
    - The OTC drug or device is obtained with a prescription order from a provider; AND
    - The OTC drug or device 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 the Plan is required to cover under federal law that are mandated as a Preventive Health Care Service.
- Certain prescription drugs that the Plan has determined are therapeutically equivalent to an over-the-counter drug. This exclusion does not apply to over-the-counter products that the Plan is required to cover under federal law that are mandated as a Preventive Health Care Service.
- Compounded drugs that contain any ingredient(s) that have not been approved by the FDA and/or that are not on the Prescription Drug Formulary and that require a prescription order or refill.
- Compounded drugs that are commercially available in a different form to treat the same disorder, unless the compounded dosage form and its components meet all standards of Medical Necessity and contains covered Drugs that cannot be administered through another commercially available product. (Compounded drugs that contain only covered ingredients that require a prescription order or refill are assigned to the highest applicable copay, or Tier 3).
- Drugs or devices that are dispensed by a Pharmacy that is a Non-Network Provider.
- Drugs or devices that are 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 those specifically stated as covered on the Prescription Drug Formulary).
- Drugs or devices that are prescribed, dispensed, or intended for use during an Inpatient

Stay.

- Drugs or devices that are prescribed, dispensed, or intended for use during a Skilled Nursing Stay.
- Drugs or devices that are prescribed for appetite suppression or for weight loss as a primary diagnosis.
- Drugs or devices that are prescribed for hyperhidrosis, sexual dysfunction as a primary diagnosis, cosmetic procedures or purposes, or onychomycosis.
- 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.
- Drugs or devices that are 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.
- Drugs or devices that are 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 2: *Definitions*.
- Growth hormone therapy used 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).
- Fertility drugs unless used to treat the medical condition that results in infertility.
- Drugs considered to be natural or homeopathic remedies, medical foods, herbal remedies or supplements, naturopathic therapies, complementary medicines, or alternative medicines.

Remember that the best way to know what drugs and devices your Prescription Drug Benefit will cover is to review the Prescription Drug Formulary. If you have any questions about whether or not a drug or device is covered, please call Member Services at the number on your ID card.

SECTION 7 – 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 5: *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. Unless otherwise stated, benefit limits are for the entire Benefit Year.

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 5: *Your Covered Services* or through a Rider/Enhancement or Amendment to this Evidence of Coverage.

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.
- 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.
- 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.
- Received to treat any Sickness or Injury that occurs while serving in the armed forces.
- Received to treat a condition resulting from direct participation in an act of terrorism, a riot, and/or civil disobedience, or resulting from exposure to a nuclear explosion, and/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.
- Health Care Services received while incarcerated in a federal, state, or local penal institution or required while in custody of federal, state, or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
- For the following Provider charges listed below:
    - 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, referred by, or received from a Provider who is a family member by birth, marriage, or ordinarily resides in the Member's home. Examples include but are not limited to a spouse, brother, sister, parent, or child. This includes any service the Provider may perform on himself or herself.
- 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 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.
- Chemonucleolysis.
- Biliary lithotripsy.
- 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 marital counseling.
- For biofeedback.
- For prescription, fitting, or purchase of eyeglasses or contact lenses.
- For vision orthoptic training.
- For hearing aids or examinations to prescribe or fit them.
- 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 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 Health Care Services related to surrogacy if the Covered Person is not the surrogate.
- For an abortion, except a Therapeutic Abortion as defined in Section 2: *Definitions*.
- For services and materials not meeting accepted standards of optometric practice.
- For visual therapy.
- For workplace/hiring physicals.

- 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 emergency response systems, unless otherwise authorized by Plan.
- For automatic medication dispensers, unless otherwise authorized by Plan.
- 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. 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 5: *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, bio-energetic synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, sleep therapy, sensory integration therapy, prolotherapy, light treatments for seasonal affective disorder, 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 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.
- For Health Care Services you receive outside of the United States other than Emergency Health Care Services or Urgent Care Services.
- Received if the Injury, Illness, or Sickness for which the Health Care Services are rendered resulted from an action or omission for which a governmental entity is liable.
- For dental services unless specified in this EOC.
- For neuropsychological testing when not considered Medically Necessary.

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 and 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 to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is 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.

SECTION 8 – 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, asthma, hypertension, and chronic kidney disease. 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

- Self-Service Tools; and
- Care Management Services.

CareSource believes in giving you the tools you need to be an educated health care consumer. We have several convenient educational and support services accessible at CareSource.com, to help you 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. It is meant 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 your choice to seek or not to seek professional medical care, or your choice of specific treatment based on the text.

24-Hour Nurse Advice Line

Health worries don't always happen during Business Hours. Our experienced nurses are available through 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 24-Hour Nurse Advice Line 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.

Integrated Care Management

If you have a serious or complicated health problem or want to learn more about your acute or chronic illness, we are here to help you navigate through the health care system to get the coordinated, quality care you need. Our experienced care management 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. In addition, our care management team can assist you with finding resources to support you and improving your overall health.

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.

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:

- View Plan documents.
- Search for Network Providers available in your Plan through the Find A Doctor lookup tool, which is available at FindADoctor.CareSource.com.
- Use the Find My Prescriptions tool as a quick way to confirm your prescription costs.

CareSource MyLife[SM]

Set up your personal online account at MyLife.CareSource.com. The registration 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 when registering.

Visit MyLife.CareSource.com to:

- Access and print or request a copy of your ID Card after your first payment is received.
- View eligibility and Benefit information, including Copayments and Annual Deductibles.
- View and pay your invoice or set up automatic payments.
- See the current status and history of your Claims.
- Complete a health needs assessment to identify health habits you can improve, learn about healthy lifestyle techniques, and access health improvement resources.

SECTION 9 – GRIEVANCE PROCESS AND ADVERSE BENEFIT DETERMINATION APPEALS

What this section includes:

- What to do if you have a Grievance;
- How to request Prior Authorizations, Predeterminations, and Medical Reviews;
- How to Appeal Adverse Benefit Determinations; and
- How to request an External Review of an Adverse Benefit Determination.

Please contact Member Services at 1-833-230-2099 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 the Grievance Process, the Internal Appeals Process, and the External Review Process. These processes are intended to provide fair, reasonable, and timely solutions to complaints and appeals that you may have concerning CareSource, Benefit determinations, coverage and eligibility issues, or the quality of care rendered by Network Providers.

The Grievance Process

We have a Grievance Process for the quick resolution of Grievances you submit to us that are unrelated to Benefits or Benefits denials. For purposes of the Grievance Process, we define a Grievance as an expression of unhappiness or dissatisfaction relating to any aspect of our operation. If you have a Grievance concerning CareSource, please contact us.

You, or an Authorized Representative, who may also be your Provider, may submit your Grievance in writing by sending a letter to us at the following address: CareSource, Attention: Indiana Member Appeals, P.O. Box 1947, Dayton, OH 45401 or by submitting your Grievance through your personal online account at MyLife.CareSource.com. You, or an Authorized Representative, may also submit a Grievance by calling Member Services at 1-833-230-2099.

We will acknowledge all Grievances submitted by you or your Authorized Representative, verbally or in writing, within three (3) Business Days of our receipt of the Grievance.

Timing of Decisions and Notifications for Grievances Unrelated to Adverse Benefit Determinations

For Grievances that are unrelated to Plan's decision to deny, reduce, terminate, or provide payment (in whole or in part) for Health Care Services, generally, we will resolve the Grievance as quickly as possible. We will investigate, resolve, and make a decision regarding the Grievance within not more than twenty (20) Business Days after the Grievance was filed. We will send you a letter explaining our resolution of the Grievance within five (5) Business Days after completing our investigation.

If, due to Circumstances Beyond the Plan's Control, we are unable to make a decision regarding your Grievance within the twenty (20) Business Day period, we will notify you in writing of the reason for the delay, not more than nineteen (19) Business Days after the Grievance is filed. We will then send a letter to you explaining the Plan's resolution of the Grievance within an additional ten (10) Business Days.

If you are unsatisfied with our decision regarding your Grievance, you or your Authorized Representative may submit an appeal, verbally or in writing, within one hundred eighty (180) days of receiving notice of our Grievance decision. We will acknowledge receipt of your appeal within three (3) Business Days after receiving the appeal request.

We will appoint a panel of qualified individuals to resolve your appeal. The panel will not consist of any individuals who were involved in the matter giving rise to the Grievance nor involved in the initial investigation of the Grievance. You have the right to appear in person at the panel or to communicate with the panel through appropriate other means if you are unable to attend in person. The appeal will be resolved not later than forty-five (45) Business Days after the appeal is filed, and we will send you written notice of the resolution of the appeal within five (5) Business Days after completing the investigation.

Timing of Decisions and Notifications for Grievances Related to Adverse Benefit Determinations

For Grievances that are related to the Plan's decision to deny, reduce, or terminate Health Care Services, we will investigate, resolve, and make a decision regarding the Grievance within fifteen (15) Business Days after the Grievance was filed.

Note: The Adverse Benefit Determination Appeal Process below addresses issues related to Benefits, Benefits denials, or other Adverse Benefit Determinations. The Adverse Benefit Determination Appeal Process, described below, is separate and distinct from the Grievance Process.

Definitions

For purposes of this section, the following definitions apply—

Adverse Benefit Determination means a decision by us to deny, reduce, or terminate benefit coverage of a health care service furnished or proposed to be furnished to a Member on the grounds that the health care service:

- Is not Medically Necessary, appropriate, effective, or efficient;
- Is not being provided in or at an appropriate health care setting or level of care;
- Is experimental or investigational;
- 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.

Clinical Peer means (A) a physician who holds a current and valid license under IC 25-1-21, if reciprocity exists, or holds a license that is part of a compact in which Indiana has entered; (B) is certified in the same specialty as the Physician under review as recognized by: the American Board of Medical Specialties or the American Osteopathic Association; and (C) if the review specifically concerns subspecialty care, is certified in the same subspecialty as the Physician

under review, as recognized by: the American Board of Medical Specialties or the American Osteopathic Association.

Prior Authorization – A determination by us that a Health Care Service has been reviewed and, based upon the information provided to us, is a Covered Service.

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 Organization (or IRO) means an entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant this section.

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

Predetermination – An Authorization that you voluntarily request before 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 or 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 do not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Peer to Peer Reconsideration of Adverse Benefit Determination

For Adverse Benefit Determinations your doctor or practitioner may request a peer to peer discussion or reconsideration review by calling the Utilization Management department.

If a peer to peer review is requested, the peer to peer discussion or reconsideration shall occur no later than forty-eight (48) hours (excluding weekends and state and federal legal holidays) from the date of the request. This review will be conducted between the requesting Provider and the reviewer who made the Adverse Benefit Determination or, if the reviewer is not available, a designee will complete the peer to peer discussion or reconsideration.

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 filed verbally or in writing and may be submitted by you or your Authorized Representative, who may also be your Provider. 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. Adverse Benefit Determination appeals based on Medical Necessity are reviewed and decided by a Clinical Peer who was not involved in prior reviews or determinations of the service or item under 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) calendar 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 verbally or electronically.

You or your Authorized Representative may send a written request for an Internal Appeal to: CareSource, Attention: Indiana Member Appeals, P.O. Box 1947, Dayton, OH 45401 or through your personal online account at MyLife.CareSource.com.

If you or your Authorized Representative would like to appeal a denied Urgent Care Request, you may submit your Internal Appeal verbally by calling Member Services at 1-833-230-2099 to request an expedited appeal or in writing through your personal online account at MyLife.CareSource.com.

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

1. The Covered Person's name and member 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.
6. A consent form signed and dated by you, authorizing your Provider or other Representative to appeal the Adverse Benefit Determination on your behalf.

Note: All Expedited Internal Appeal requests should be made verbally. However, this is not required, and you may still submit Expedited Internal Appeal requests in writing.

Standard Internal Appeal

Within three (3) Business Days after receiving a request for a Standard Internal Appeal, the Plan will acknowledge receipt of the Standard Internal Appeal by providing notice, verbally or in writing, to you and your Authorized Representative.

The Plan will make a decision on your Standard Internal Appeal as expeditiously as possible, but not more than thirty (30) calendar days after your Standard Internal Appeal is filed and all necessary information to complete the review is received. The Plan will notify you and your Authorized Representative, in writing, of the decision of your Standard Internal Appeal within five (5) Business Days after making a decision.

However, if, due to Circumstances Beyond the Plan's Control, we are unable to make a decision regarding your Standard Internal Appeal within the thirty (30) calendar days period, we will notify you in writing of the reason for the delay, not more than thirty (30) calendar days after the Standard Internal Appeal is filed. We will then send a letter to you explaining the Plan's resolution of the

Standard Internal Appeal within an additional ten (10) Business Days.

Note: In no event will the Plan take longer than thirty (30) calendar days after receipt of your Prospective Care Internal Appeal to provide you notification of our decision regardless of whether the Plan has received all necessary information or sixty (60) calendar days after receipt of your Retrospective Care Internal Appeal to provide you notification of our decision regardless of whether the Plan has received all necessary information.

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

Expedited Internal Appeal

You may request an Expedited Internal Appeal of an Adverse Benefit Determination for:

- Any request for Health Care Services when the time periods for making non-Urgent Care 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 condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
    - Except as provided below, whether a claim 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 claim that a Physician with knowledge of your medical condition determines is a claim involving Urgent Care Services.
- Any claim involving an admission, availability of care, continued stay or Health Care Service for which you have received Emergency Health Care Services, but have not been discharged from a facility.

After receiving a request for an Expedited Internal Appeal, the Plan will acknowledge receipt of the Expedited Internal Appeal by providing notice, verbally or in writing, to you and your Authorized Representative as soon as possible (taking into account the likelihood of death, permanent injury, improvement, or deterioration of your health and your ability to reach and maintain maximum function). The acknowledgment will be provided to you no more than three (3) Business Days after receipt of your request for Expedited Internal Appeal.

We will complete the expedited review of your Internal Appeal and notify you of our decision as soon as possible given your medical needs, but no later than forty-eight (48) hours after our receipt of the request. All necessary information, including our decision, will be transmitted to you and your Authorized Representative by telephone, fax, or other available similarly expeditious method. We will also provide written notice of our determination to you and your Authorized Representative.

Review of Internal Appeal and Decision

The Internal Appeal, whether Standard or Expedited, will be reviewed by one (1) or more

individuals who have knowledge in the medical condition or Health Care Service at issue; are in the same licensed profession as the Provider who proposed, refused, or delivered the Health Care Service; are not involved in the matter giving rise to the Internal Appeal or previous Grievance process; do not work for the individual who made the Adverse Benefit Determination; and do not have a business relationship with you or the Provider who previously recommended the Health Care Service giving rise to the Internal Appeal.

You and your Authorized Representative have the right to review your claim file and submit written comments, documents, records, and other information relating to your Internal Appeal. Furthermore, upon request and free of charge, you will be provided reasonable access to, and copies of, all documents, records, and other information relevant to your Internal Appeal.

If the Plan's decision on Internal Appeal is still adverse to you, we will provide you and your Authorized Representative with a Final Adverse Benefit Determination notice within appropriate timeframes, as noted above, for Standard and Expedited Internal Appeals.

Exhaustion of Internal Appeals Process

The Internal Appeals 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 or Final Adverse Benefit Determination 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.

Request for External Review

You or your Authorized Representative must request an External Review through us within one hundred twenty (120) days of the date of the notice of an Adverse Benefit Determination or Final Adverse Benefit Determination issued by us. All External Review requests must be in writing, except for a request for an Expedited External Review, which may be requested verbally 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.

You or your Authorized Representative may send a written request for an External Review to: CareSource, Attention: Indiana Member Appeals, P.O. Box 1947, Dayton, OH 45401. Phone: 833-230-2099.

If you or your Authorized Representative would like to file an Expedited External Review, you may submit your request for expedited External Review verbally by calling us at 1-833-230-2099.

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

1. The Covered Person's name and member 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 or Final Adverse Benefit Determination; and
5. Any documentation or other written information to support your request.

Note: You may file only one request for External Review of your Adverse Benefit Determination or Final Adverse Benefit Determination.

Note: The Expedited External Review process can also occur at the same time as an Expedited Internal Appeal.

Note: If you have the right to an External Review under Medicare (42 U.S.C. 1395, et seq.), then you may not request an External Review of an Adverse Benefit Determination under the procedures outlined in the Plan.

Reconsideration of Adverse Benefit Determination

If at any time during the External Review process, you submit new information to us that is relevant to our Adverse Benefit Determination or Final Adverse Benefit Determination notice and was not considered by us, we must reconsider our Adverse Benefit Determination or Final Adverse Benefit Determination and the Independent Review Organization will cease its External Review. We will consider our Adverse Benefit Determination or Final Adverse Benefit Determination based upon the new information and notify you of our decision within seventy-two (72) hours after the information is submitted for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize your life or health, or your ability to reach and maintain maximum function or within fifteen (15) calendar days after the information is submitted for all other situations. If our decision is still adverse to you, you may request that the Independent Review Organization resume the External Review.

External Review Conducted by Independent Review Organization

There are two (2) types of External Reviews conducted by Independent Review Organizations (IRO): (1) Standard and (2) Expedited.

Standard External Review Conducted by an Independent Review Organization

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

- The following determinations made by us or our agent regarding a Health Care Service proposed by a treating Physician:
  - Adverse utilization review determination, as outlined above.
  - An Adverse Benefit Determination of medical necessity.
  - A determination that the proposed Health Care Service is experimental or investigational.
- Our decision to rescind your coverage under the Plan.

Expedited External Review Conducted by Independent Review Organization

You are entitled to an Expedited External Review by an Independent Review Organization when the External Review:

- 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.
- Is related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize your life or health or your ability to reach and maintain maximum function.

Independent Review Organization Assignment

When we initiate an External Review by an Independent Review Organization, we will select an Independent Review Organization from a list of Independent Review Organizations that are certified by the Indiana Department of Insurance. We select a different Independent Review Organization for each request for External Review filed and rotate the choice of Independent Review Organization among all certified Independent Review Organizations before repeating a selection. The Independent Review Organization will assign a medical review professional who is board certified in the applicable specialty for resolution of the External Review. An Independent Review Organization that has a material professional, familial, financial, or other affiliation, or conflict of interest with us, our management, you, your Provider, the proposed drug, therapy, or device, or the Facility will not be selected to conduct the External Review.

Independent Review Organization Review and Decision

The IRO must consider all documents and information considered by us in making the Adverse Benefit Determination or Final Adverse Benefit Determination, any information submitted by you, and other information such as: your medical records, your attending Provider's recommendation, consulting reports from appropriate Providers, 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. We agree to cooperate with the Independent Review Organization throughout the External Review process by promptly providing any information requested by the Independent Review Organization. The Independent Review Organization is not bound by any previous decision reached by us.

You are required to cooperate with the Independent Review Organization by providing any requested medical information, or by authorizing the release of necessary medical information. You are also permitted to submit additional information relating to the proposed service throughout the External Review process. You are permitted to use the assistance of other individuals, including Physicians, attorneys, friends, and family members throughout the External Review process.

For a Standard External Review, the Independent Review Organization should make its determination within fifteen (15) Business Days after a Standard External Review request is filed and provide written notice to you and the Plan of its determination within seventy-two (72) hours after making its determination. For an Expedited External Review, the Independent Review Organization should make its determination and notify you and the Plan within seventy-two (72) hours after the Expedited External Review is filed.

After receiving notice from the Independent Review Organization of its determination, you may request that the Independent Review Organization send you all information necessary for you to understand the effect of the determination and the manner in which the Plan may be expected to respond to the Independent Review Organization's determination.

Binding Nature of External Review Decision

An External Review decision is binding on us. An Independent Review Organization is immune from civil liability for actions taken in good faith in connection with an External Review. The work product and/or determination issued by the Independent Review Organization will be admissible in any judicial or administrative proceeding. The documents and other information created and reviewed by the Independent Review Organization or medical review professional in connection with the External Review are not public records, cannot be disclosed as public records, and must be treated in accordance with confidentiality requirements of state and federal law.

If You Have Questions About Your Rights or Need Assistance

Questions regarding your policy or coverage should be directed to Member Services at 1-833-230-2099.

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone, or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at in.gov/idoi/consumer-services.

Language Services

If you request language services, then we will provide service in the requested language through bilingual staff or an interpreter. If requested, we will provide language services to help assist you in registering a Grievance or appeal, and notify you about your Grievance or appeal.

SECTION 10 – 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 Amount.

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 maintenance organizations (HMO), and subscriber contracts; uninsured arrangement of group or group-type coverage; group or non-group coverage through closed Panel Health Plans; other group-type contracts; medical care components of long-term care contracts, such as skilled nursing care; medical benefits in automobile "no fault" and traditional automobile "fault" type contracts; and Medicare or any other federal governmental Health Plan, as permitted by law.

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; limited health benefit coverage; school accident type coverage covering grammar, high school, and college students for accident only; benefits for non-medical services in long term care policies that pay a fixed daily benefit without regard to expenses incurred or the receipt of services in 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 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.

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 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 the Primary Health Plan's 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 Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a Benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a 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 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 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Health Plan's payment arrangement shall be the Allowable Expense for all 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 Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions,

precertification of admissions, and preferred Provider arrangements.

E. If applicable, a Closed Panel Health Plan is a Health 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 Health 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 calendar year excluding any temporary visitation.

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 Health Plan.

1. Except as provided in Paragraph (2), a Health Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Health 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 will be excess to any other parts of the Health Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Health Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Health Plan to provide out-of-network benefits.

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

Each Health 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.
2. 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:
        i. The Health Plan of the parent whose birthday falls earlier in the calendar year is the Primary Health Plan; or

ii. If both parents have the same birthday, the Health Plan that has covered the parent the longest is the Primary Health Plan.

iii. However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that 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. If the parent with the responsibility has no health care coverage for the dependent child's health care expense, but that parent's spouse does, that parent's spouse's plan is the primary plan. This rule does not apply with respect to any Claim determination period or plan year during which any benefits are actually paid or provided before the Health Plan has actual knowledge of the terms 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.

3. 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 D(1) can determine the order of benefits.

4. 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 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.

5. Longer or shorter length of coverage. If the preceding rules do not determine the order of benefits, 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.
6. 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 Health Plan is the Secondary Health Plan, it may reduce its benefits so that the total Benefits paid or provided by all Health 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 Health Plans for the Claim do not exceed the total Allowable Expense for that Claim. In addition, the Secondary Health Plan will credit to its 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 Health Plans and if, for any reason, including the provision of service by a non-panel Provider, Benefits are not payable by one Closed Panel Health Plan, COB shall not apply between that Health Plan and other Closed Panel Health 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 calling Member Services. Please also refer to the appeals procedures listed in this EOC. If you are still not satisfied, you may call the Indiana Department of Insurance for instructions on filing a consumer complaint. Call 1-800-622-4461, (317) 232-2395 or visit the Department's website at in.gov/idoi.

SECTION 11 – 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, CareSource has 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, it has the legal right to substitute itself for you for the limited purpose of making a claim to recover the Benefits it 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 it 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 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 us 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 us.

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) have paid or are owed.

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 12 – 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 3: *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 we discontinue a particular product provided that we provide you with written notice at least ninety (90) days before the date the product will be discontinued, we offer you the option to purchase any other individual contract we currently offer, and we act uniformly without regard to any health status-related factor.

If we discontinue all contracts in the individual market in Indiana if we provide you and the Indiana Department of Insurance with written notice at least one hundred eighty (180) days before the date of the discontinuance, we discontinue and do not renew all contracts we issue or deliver for issuance in the State of Indiana in the individual market, and we act uniformly without regard to any health status-related factor.

We may, at the time of renewal, modify the Plan if the modification is consistent with the laws of the State of Indiana and is effective uniformly for all persons who have coverage under this type of contract.

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 800-318-2596. The termination effective date may be effective as soon as fourteen (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.

Notice of Termination and Date of Termination

The Marketplace and the 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 thirty (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.

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; (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 because (a) you terminate coverage under this Section 12, (b) you fail to pay Premium within the applicable Grace Period set forth in Section 3: *How the Plan Works*; or (c) CareSource's insolvency or end of operations. 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 the Plan 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) make 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 9: *Grievance Process 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.

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 your Benefits were terminated for non-payment, you may request reinstatement of your Benefits from us within thirty (30) days of the effective date of termination. You must remit all Premium that was due for the Benefits upon reinstatement. Upon receipt of the outstanding Premium, we will reinstate Benefits as of the effective date of termination.

SECTION 13 – 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 2: *Definitions*, 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 2: *Definitions*, 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'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;
- 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;
- paying, directly to your Provider, the cost of any Non-Covered Service; and
- 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 Indiana for the practice of medicine, osteopath, optometry, chiropractic, podiatry, psychology, or dentistry, such Benefits will not be denied when such Covered Service is rendered by a Network Provider licensed in the State of Indiana as a physician, osteopath, optometrist, chiropractor, podiatrist, 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 authority 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. If we exercise our right not to renew your Benefits under the Plan, it will not take effect until the renewal date occurring on, or after and nearest, each Plan anniversary date and will not be based on any Claim originating while the Plan is in effect.

Payment of Benefits

When your care is rendered by a Network Provider you are not required to file a Claim. Since no claim filing is required, the provisions below regarding "Notice of Claim" and "Claim Forms" do not apply.

You authorize us to make payments directly to Providers giving Covered Services. We also reserve the right to make payments directly to you. Claims may be submitted by you or a Provider.

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 CareSource.com/marketplace or by calling Member Services.

Notice of Claim

Written notice of a Claim must be given to us within twenty (20) 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 3607, Dayton, Ohio 45401-3607, 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 proof 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 (1) 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 3607, Dayton, Ohio 45401-3607.

Payment of Claim

We will pay or deny a clean Claim filed electronically within thirty (30) days or within forty-five (45) days if filed on paper except services protected under the Federal No Surprises Act as noted in the subsequent paragraph. A "clean Claim" means a Claim submitted 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 thirty (30) days after receipt of a Claim electronically and within forty-five (45) days if the Claim is submitted on paper. This notice will detail the supporting documentation needed. We will complete the processing of the Claim within fifteen (15) days after our receipt of all requested information. You and your Provider will be notified when a Claim is denied. The notification will include the reason(s) for the denial. Claims submitted by Providers are also governed by Indiana Code § 27-13-36.2.

Claims for services under the Federal No Surprises Act, 42 U.S.C. §300gg–111, will pay or deny within thirty (30) calendar days. These services include Emergency services, air Ambulance, and services from Non-Network Providers performed at a Network Hospital, Hospital outpatient department, critical access Hospital, Ambulatory Surgical Center, free-standing emergency department, and any other Facility, specified by the Secretary, that provides items or services for which coverage is provided under the Plan or Coverage. Please refer to additional information throughout this Evidence of Coverage regarding these services and the Member No Surprises Act Protections.

Coverage through Non-custodial Parent

Whenever a child under the age of eighteen (18) is an enrolled Dependent under the Plan through a non-custodial parent, we shall upon the written request of the non-custodial parent, do any of the following:

- Provide any information to the custodial parent that is necessary for the child to obtain Benefits under the Plan.
- Permit the custodial parent, or the Provider with the custodial parent's approval, to submit Claims for Covered Services without the non-custodial parent's approval.
- Pay Claims submitted by the custodial parent or the Providers directly to the custodial parent or Provider.

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.

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 Member Services number on the back of your ID Card if you have any questions.

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 forty eight (48) hours following a vaginal delivery or less than ninety six (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 forty-eight (48) hour (or ninety-six (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 forty-eight (48) hours (or ninety-six (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.

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for equality in the insurance coverage, treatment limits and financial coverage, of behavioral health/substance use disorder benefits and medical/surgical benefits. Generally, a plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on behavioral health and substance use disorder benefits. Additionally, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on behavioral health and substance use disorder benefits that are more restrictive than those applicable to other medical/surgical benefits.

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.

Victims of Abuse

We will not deny or refuse to issue coverage, refuse to contract with or refuse to renew coverage, refuse to reissue, or otherwise terminate or restrict coverage on an individual under this Plan because the individual has been, is or has the potential to be a victim of abuse or seeks, has sought, or should have sought protections from abuse, shelter from abuse, or medical or psychological treatment for abuse. We will not add any surcharge or rating factor to a Premium because an individual has a history of being, is or has the potential to be a victim of abuse. We will not exclude

or limit coverage for losses or deny a Claim incurred by a Covered Person as a result of abuse or the potential for abuse. We will not ask a Covered Person or individual applying for coverage under the Plan whether such individual is, has been, or may be the victim of abuse or seeks, has sought, or should have sought protection from abuse, shelter from abuse, or medical or psychological treatment for abuse.

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, Amendments, and documentation submitted to the Marketplace and CareSource, constitute the entire legal contract between you and us, and as of the effective date of your coverage, supersede all other agreements between us. This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of CareSource and unless such approval be endorsed heron or attached hereto. No insurance producer has authority to change this policy or to waive any of its provisions. 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.

The benefits under this Plan for Covered Persons aged 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.

Under the Social Security Act, a health plan may not sell or issue an Individual Market Exchange Qualified Health Plan (or an individual market policy outside the Exchange) that duplicates Medicare or Medicaid benefits of which a beneficiary is entitled. This prohibition does not apply to a renewal of coverage under the same policy or contract of insurance.

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 medicare.gov/publications.

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, pre-existing conditions, 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, pre-existing conditions, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and 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: qualified interpreters, and information written in other languages. If you need these services, please contact CareSource at 1-833-230-2099 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 ocrportal.hhs.gov, 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 hhs.gov/ocr/complaints/index.html.

Member No Surprises Act Protections

The federal government passed the No Surprises Act (NSA) to create certain protections for people that receive emergency medical care, receive covered treatment from a Non-Network Provider while visiting a Network Hospital, freestanding emergency department, urgent care, or ambulatory surgical center, or receive covered air ambulance services by an out-of-network air ambulance Provider. The NSA instituted laws and protections that prevent Members from receiving surprise, balance bills in such situations from Providers (including Physicians, billing practitioners, and air ambulance Providers). The Member will be responsible for any applicable cost-sharing obligations and will not be balance billed for such services. Further, Prior Authorization is not required for emergency medical care. CareSource Members that receive Emergency Services for an Emergency Medical Condition will only be financially responsible for in-network cost-sharing amounts as a result of the care.

Other services provided by Non-Network Providers (including emergency medical care, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services) at a Network Hospital or ambulatory surgical center, may also only result in Member financial responsibility for in-network cost-sharing amounts. You may only be balance billed for non-emergency medical services by a Non-Network Provider while receiving treatment at an in-network Facility if you sign a specific Provider authorization and approve these services.

You are never required to give up your protections from balance billing or to receive out-of-network care. Instead, you may choose a Provider or Facility that is within CareSource's Network.

As well, the NSA provides protections for continuing care patients whose Provider or Facility ceases to be a Network Provider because of a contract termination. This election status continues for 90 days, or at which time the Member is no longer a continuing care patient. For these Members, CareSource will:

- Timely notify each Member of the termination and their right to elect continued transitional care from the Provider or Facility;
- Provide each Member an opportunity to notify CareSource of the need for transitional care; and
- Permit the Member to elect to continue to have the same Benefits provided, under the same terms and conditions as would have applied under the Plan or Coverage had the termination not occurred, with respect to the course of treatment furnished by the Provider or Facility.

CareSource provides tools to help you make the most of your Coverage:

- Provider Directories are your primary resource to confirm a Provider is in-network which will help ensure the lowest cost of care. Provider Directories are available both online and in print.
    - The NSA requires Plans and Providers to improve the accuracy of Provider Directory information. Under the NSA, if a Member relies on incorrect Provider Directory information and, as a result, receives items or services from a Non-Network Provider or health care Facility, the Member will only be responsible for in-network cost sharing amounts.
- Cost Estimator Tool can be used to get an estimate of your cost share for specific services with specific Providers. This tool is available online through your CareSource MyLife account.

You can also call Member Services for assistance.

Conformity with Law

This Plan shall be construed under the laws of the State of Indiana. Any provision of this Plan which is in conflict with the laws of Indiana 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 an 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 us 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 any or all of the following: manual calling methods, prerecorded or artificial voice messages, text messages, written correspondence, emails and automatic telephone dialing systems. You agree that CareSource and its affiliates, agents and service providers may use any email address and 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.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding 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.

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 Indiana. 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®

1-833-230-2099
(TTY/TDD: 711)
CareSource.com/marketplace

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