CARESOURCE (COMMON GROUND HEALTHCARE)

INDIVIDUAL & FAMILY PLAN WITH VISION BENEFIT CERTIFICATE OF COVERAGE, AMENDMENTS AND NOTICES

Certificate ID Number: POLMP-WI(2026)V v2

Effective Date: January 1, 2026
Offered and Underwritten by Common Ground Healthcare Cooperative

CareSource (Common Ground Healthcare)

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CareSource.com/Marketplace
877-514-2442

IMPORTANT NOTICES

This Certificate of Coverage outlines the terms and conditions of your insurance coverage. This is the contract that CareSource (Common Ground Healthcare) ("CareSource") holds with you in consideration of your application and Premium payment.

It is important that you read your Policy documents carefully and store it in a place where you can refer to it. This Certificate of Coverage, along with any attached Riders or Amendments, will explain your Benefits and other important information about your health insurance coverage. The following are important disclosures you should read through regarding your Policy.

CERTIFICATE OF COVERAGE
This Certificate is part of the Policy and is a legal document between CareSource and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions, and limitations of the Policy. In addition to this Certificate, the Policy includes the Schedule of Benefits, any Amendments and Riders, Notices, and your Application.

PLEASE BE AWARE THE POLICY DOES NOT PAY FOR ALL HEALTH SERVICES
Your right to Benefits is limited to Covered Health Services. The extent of the Policy's payments for these Covered Health Services and any obligation that you may have to pay for a portion of the cost of these Covered Health Services is set forth in the Schedule of Benefits. There are NO Benefits for services provided by Out-of-Network Providers, except in very limited circumstances outlined in the Limited Covered Health Services from Out-of-Network Providers provision. Please refer to ***Section 7: Covered Health Services*** and ***Section 9: Exclusions*** for Limited Covered Health Services. Also, see Balance Billing explanation in ***Section 2: Terms and Definitions*** **and** ***Section 5: How to Obtain Covered Health Services.***

YOUR RIGHT TO RETURN POLICY
Please read your Policy, including this Certificate, immediately. If you are not satisfied with it for any reason, you can return it within 10 days of receipt of the Policy. Upon return, the Policy becomes invalid. CareSource will refund any Premium payments you have made, less any claims paid by Us.

GUARANTEED RENEWABILITY
The Policy is guaranteed renewable unless one of the exceptions in ***Section 4: When Coverage Begins and Ends*** becomes applicable. You must be eligible for insurance and pay your Premium to remain insured.

COVERAGE UNDER THE POLICY IS LIMITED TO IN-NETWORK PROVIDERS
The Policy is an Exclusive Provider Organization (EPO) Plan. Covered Health Services must be provided by an In-Network Provider. In-Network Providers have agreed to accept Our contracted rate for Covered Health Services with no additional billing to the Covered Person other than Copayment, Coinsurance and Deductible amounts. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits. You may be billed by your In-Network Provider(s) for any non-Covered Health Services you receive or when you have not acted in accordance with the Policy.

NO BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED

In most cases, there is no coverage for Covered Health Services provided by Out-of-Network Providers. You will be fully responsible for payment of care provided by Out-of-Network Providers. However, you may receive care for Covered Health Services from Out-of-Network Providers in these limited circumstances: Emergency Health Services, for out of Service Area Urgent Care, and for services CareSource determines qualify in the limited Covered Health Services from Out-of-Network Providers provision. In these limited circumstances, the amount paid is limited to the Maximum Allowed Amount as defined in ***Section 2: Terms and Definitions*** of this Certificate. You may be responsible for paying any difference between the amount the Out-of-Network Provider charges and the Maximum Allowed Amount. See Balance Billing explanation in ***Section 2: Terms and Definitions*** **and** ***Section 5: How to Obtain Covered Health Services.***

You may obtain further information about the status of Providers and information on out-of-pocket expenses by calling Member Services at 877-514-2442 or by clicking on the "Find a Doctor" button located on Our website: findadoctor.caresource.com.

THE POLICY CONTAINS A PRIOR AUTHORIZATION REQUIREMENT

Benefits may be reduced or excluded if you fail to pre-authorize certain treatment and procedures. Read the Prior Authorization provision carefully. Prior Authorization is not a guarantee of payment.

THE POLICY DOES NOT CONTAIN PEDIATRIC DENTAL SERVICES

The Policy does not include pediatric dental services that are required under the federal Patient Protection and Affordable Care Act. You may purchase a stand-alone dental care plan through the Marketplace, Healthcare.gov.

STATEMENTS MADE IN YOUR APPLICATION

Please submit any corrections to your application in writing within 10 days if any information submitted in your application is incorrect or incomplete. Misstatements or omissions in the application could cause an otherwise valid claim to be denied. The insurance coverage was issued on the basis that the answers to all questions and other information shown on the application is correct and complete.

CHANGES TO THE CERTIFICATE OF COVERAGE AND EFFECTIVE DATES

CareSource has the right to change, interpret, modify, withdraw, add Benefits, or to terminate the Policy, as permitted by law, without your approval. We may, from time to time, modify this Certificate by attaching legal documents called Riders and/or Amendments that may change certain provisions of this Certificate. When that happens, We will notify you and provide access to the new Certificate, Rider or Amendment pages. No one can make any changes to the Policy unless those changes are in writing.

On its Effective Date, this Certificate replaces and overrules any Certificate that We may have previously issued to you. This Certificate will be overruled by any future Certificate We issue to you.

The Policy will take effect on the date specified on your member ID card. Coverage under the Policy will begin at 12:00 midnight on your Effective Date and end at 11:59 pm Central Time on the date of your termination. The Policy will remain in effect as long as the Policy Premiums are paid when they are due, subject to the 'When Coverage Ends' provision of the Policy. We are delivering the Policy in the State of Wisconsin.

NOTICES

CareSource provides written notice regarding administration of the Policy to you as the Authorized Representative of the Policy and that notice is deemed notice to all affected Subscribers and their Enrolled Dependents.

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SECTION 1: INTRODUCTION

This section includes information on:

- **How to use this document**
- **Please do not hesitate to contact us**

Thank you for becoming a member of CareSource. This Certificate of Coverage (referred to simply as your Certificate) describes your Benefits including Covered Benefits, exclusions and limitations as well as your rights and responsibilities as an insured member of CareSource. We encourage you to read your Certificate, your Schedule of Benefits and attached Riders and/or Amendments carefully. You may call 877-514-2442 to request that a printed copy of this Certificate be mailed to you.

This Certificate is your main source of information regarding the Benefits available to you under the Policy. If there is a conflict between this Certificate and any summaries provided to you either verbally or in writing, this Certificate will control with respect to Benefits for Covered Persons.

HOW TO USE THIS DOCUMENT

Please review the table of contents for this document to understand how the document is organized. Many of the sections of this Certificate are related to other sections of the document so you may not have all the information you need by reading just one section.

We encourage you to review the Benefits and the Exclusions and Limitations of this Certificate by reading the Schedule of Benefits along with ***Section 7: Covered Health Services and Limitations*** and ***Section 9: Exclusions***. You should also carefully read ***Section 11: General Legal Provisions*** to better understand how this Certificate and your Benefits work. Please do not hesitate to contact Us at 877-514-2442 if you have questions about the limits of the coverage available to you.

When We use the words "We", "Us", and "Our" in this document, We are referring to CareSource. When We use the words "member", "you" and "your", We are referring to people who are Covered Persons, which is defined in ***Section 2: Terms and Definitions***.

Because this Certificate is part of a legal document, We also include definitions that will help you understand the document. If a word is capitalized in the document, it likely has a special meaning and is defined in ***Section 2: Terms and Definitions***.

Please be aware that your Provider is not responsible for knowing or communicating your Benefits.

This is an Exclusive Provider Organization (EPO) health insurance plan, which means there are not any Out-of-Network Providers contracted to provide care with this health Plan. According to the terms described in this Certificate of coverage, We reimburse or pay, for Plan Covered health care services. Plan terms that impact coverage determinations and reimbursement amounts include, but are not limited to Deductible, Copayment and Coinsurance amounts.

Prior Authorization requirements, which are based on whether a service or item is:

- Needed to diagnose or treat an Illness or Injury,
- Medically Necessary,
- Whether the Provider is In-Network,
- Your Plan's Maximum Out-of-Pocket Limit, and
- Whether you have met it for the current Plan year Benefit limits.

SECTION 1: INTRODUCTION

To provide care to Our members, We have contracted with health care Providers which form Our Exclusive Provider Network. As a member of this health Plan, you may choose which Providers you see within this network.

PLEASE DO NOT HESITATE TO CONTACT US

Throughout the document, you will find statements that encourage you to contact Us for further information. Whenever you have a question or concern regarding your Benefits, claims, Providers, Premium, invoices or other questions, please call Member Services at 877-514-2442. This number is also listed on your ID card. Helping Our members understand their Benefits is an important part of Our mission as a non-profit, and it will be Our pleasure to assist you when you call.

SECTION 2: TERMS AND DEFINITIONS

Activities of Daily Living (ADL) – a basic task that most people are able to do each day without any help, including but not limited to bathing, eating, dressing, toileting, and transferring.

Advance Premium Tax Credit (APTC) – a tax credit calculated by the Federally Facilitated Marketplace (FFM) that you can take in advance to lower your monthly health insurance payment.

Adverse Benefit Determination – a denial, reduction, termination of a Benefit, or failure to provide or make payment for a Benefit, in whole or in part, that is based on a determination of a Covered Person's eligibility to participate in a plan. Adverse Benefit Determination also includes a Rescission of Coverage.

Agent – a person or business who can assist you in evaluating Plan options and applying for coverage and enroll in a Qualified Health Plan (QHP) through the Federally Facilitated Marketplace.

Alternate Facility – a health care facility that is not a Hospital which provides one or more of the following services on an outpatient basis, as permitted by law: Surgical services, Emergency Health Services, Rehabilitative, laboratory, Diagnostic or therapeutic services or Mental Health Services or Substance Use Disorder Services including on an Inpatient Confinement basis.

Amendment – any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by Us. Amendments are subject to all conditions, limitations, and exclusions of the Policy, except for those that are specifically amended.

Appeal – a formal written request to reconsider a previous Adverse Benefit Determination by CareSource.

Authorized Representative – a person appointed by you with the right to act on your behalf.

Autism Spectrum Disorders – a group of neurobiological disorders that includes Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

Balance Billing – when the Provider bills you the difference between the Provider's billed amount and CareSource's Maximum Allowed Amount. For example, an Out-of-Network Provider charges $100 and the allowed amount is $70, the Provider may bill you the remaining $30. See Balance Billing explanation in ***Section 5: How to Obtain Covered Health Services.***

Benefit(s) – the maximum amount that will be allowed for a Covered Health Service under the Policy subject to applicable limits, Deductibles, Copays, Coinsurance and Out-of-Pocket Maximums. Benefits may be expressed in many ways, such as the dollar amount, number of days or the number of services. Your right to Benefits is subject to the terms, conditions, limitations, and exclusions of the Policy, including this Certificate, the Schedule of Benefits, and any attached Riders and/or Amendments.

Certificate – the document providing details of your Benefits. It is attached to and is a part of the Policy. Also see the definition of Policy.

Claim – a submitted bill for a member's received services by a Provider.

Coinsurance – the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services, after you have met your Deductible.

Complaint – your verbal expression of dissatisfaction with CareSource or any In-Network Provider.

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

Copayment (Copay) –- a fixed amount a member pays to the Provider for a Covered health care service. The fixed dollar amount may vary by the type of service (e.g., Primary Care office visit, Urgent Care visit). A Copayment applies toward your Out-Of-Pocket Maximum and is typically collected at the time of service.

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

Cost Share – the share of costs for services Covered by your insurance that you pay out of your own pocket. This term generally includes Deductibles, Coinsurance, and Copayments, or similar charges, but it doesn't include Premiums, Balance Billing amounts for Out-of-Network Providers, or the cost of excluded services.

Covered – CareSource may use the term "Covered" to communicate that Benefits will apply to a service subject to applicable limits, Deductibles, Copays, Coinsurance and Out-Of-Pocket Maximums. Covered does not mean it is necessarily paid in full.

Covered Health Service(s) – services, supplies, or Pharmaceuticals that are:

- Medically Necessary, and
- Described as a Covered Health Service in this Certificate under ***Section 7: Covered Health Services and Limitations*** and in the Schedule of Benefits, and
- Not otherwise excluded in this Certificate under ***Section 9: Exclusions,*** and
- Provided to prevent, diagnose or treat a Sickness, Injury, Mental Illness, Substance Use Disorder Service, or their symptoms.

Covered Person(s) – either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this Certificate are references to a Covered Person.

Custodial Care – services for the purpose of assisting in personal care. Typically, Custodial Care is care which is not expected to improve a medical condition or has minimal therapeutic value or is to maintain a person's current level of function. Generally, this type of care can be provided by someone who does not have professional medical training or skills. Some care is Custodial even if it is provided by a registered nurse, licensed practical nurse or other trained medical personnel. Some examples of Custodial Care are:

- Non-health-related services, such as assistance in Activities of Daily Living (examples include feeding, dressing, bathing, transferring, and assistance with walking).
- Care for members who have reached the maximum level of physical or Mental function or who cannot participate in any therapeutic activities.
- Health-related services that are provided for the primary purpose of meeting the personal needs

of the patient or maintaining a level of function (even if the specific services are skilled services), and prevents a loss of function, but does not result in improvement that might allow for a more independent existence. Some examples of this include administration of medications, enteral feedings, hygiene, simple wound care, care for feeding tubes or catheter care.
- Services given when no further gains in functional status are likely to occur.
- Services that are not required to be administered by trained medical personnel to be delivered safely and effectively.

Deductible – the amount of Eligible Expenses you must pay for Covered Health Services per year before We will begin paying for Covered Health Services. The amount that is applied to the Deductible is calculated based on Eligible Expenses. The Deductible does not include any amount that exceeds Eligible Expenses. Refer to the Schedule of Benefits for any applicable Deductible amount and how it applies.

Dependent – the Subscriber's legal spouse or Dependent child of the Subscriber or the Subscriber's spouse who lives within the Service Area. A Dependent does not include anyone who is also enrolled as a Subscriber.

The term child includes any of the following:
- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child of an Enrolled Dependent child (until the Enrolled Dependent who is the parent turns 18).

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the calendar year in which the child turns 26 years of age.

A Dependent also includes:
- Any Dependent child under 26 years of age who is not eligible for coverage under a group health Benefit plan offered by their employer and for which the amount of the Dependent's Premium contribution is no greater than the Premium amount for his or her coverage as a Dependent under the Subscriber's Plan.
- A Dependent child of any age who is or becomes disabled and dependent upon the Subscriber.
- A child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

A Dependent also includes an adult child who meets all the following requirements:
- A full-time Student, regardless of age.
- Not married or eligible for coverage under a group health Benefit plan offered by their employer and for which the amount of the Dependent's Premium contribution is no greater than the Premium amount for his or her coverage as a Dependent under the Subscriber's Plan.
- Was under age 27 when called to Federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the Dependent was attending on a full-time basis an Institution of Higher Learning. If the adult Dependent ceases to be a full-time Student due to a Medically Necessary leave of absence, then coverage must be continued in accordance with the existing law for continued coverage of Students on medical leave, and age is not a factor that would affect when such continued coverage would end.

The Subscriber must reimburse CareSource for any Benefits that CareSource pays for a child at a time when the child does not satisfy these conditions.

Designated Facility – a facility that has entered into an agreement with Us, or with an organization contracting on Our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is an In-Network Hospital does not mean that it is a Designated Facility.

Designated Pharmacy – a pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is an In-Network Pharmacy does not mean that it is a Designated Pharmacy.

Designated Provider – a Provider that We have identified through Our designation programs as a designated Provider. A Designated Provider may or may not be located within your geographic area. The fact that a Provider is an In-Network Provider does not mean that he or she is a Designated Provider.

Diagnostic Care – tests or services that are done to determine the presence of a medical condition when symptoms are present.

Durable Medical Equipment – medical equipment that is all the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Effective Date – the date that a Subscriber's coverage begins under this Certificate. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise indicated in this Certificate.

Eligible Expenses – the amount We determine will be paid for Benefits subject to the Maximum Allowed Amount.

Eligible Person – a person who meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside within the Service Area.

Emergency – a serious medical condition or symptom including severe pain of a sudden or recent onset and severity resulting from Injury, Sickness or Mental Illness which would lead a prudent layperson with an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention would likely result in any of the following:

- Serious jeopardy to the person's health or, with respect to a Pregnant woman, serious jeopardy to the health of the woman or her unborn child.
- Serious impairment to the person's bodily functions.
- Serious dysfunction of one or more of the person's body parts.

SECTION 2: TERMS AND DEFINITIONS – Listed alphabetically

Emergency Health Services – health care services and supplies received for the treatment of an Emergency from an ambulance Provider , Hospital Emergency facility, freestanding Emergency medical facility, or comparable Emergency facility to stabilize a medical condition.

Enrolled Dependent – a Dependent who is properly enrolled under the Policy.

Exclusive Provider Organization (EPO) – a managed care plan where services are Covered only if you go to doctors, specialists, Hospitals, or ancillary providers/facilities in the plan's network (except in an Emergency).

Experimental or Investigational Service(s) – medical, surgical, Diagnostic, psychiatric, Mental Health, Substance Use Disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, are used for a member's Sickness or Injury, that, at the time it is used, meets one or more of the following:

- Not proven or recognized as standard of care
- There is no credible, scientific, evidence-based literature to be of benefit for the diagnosis or treatment of a Sickness or Injury.
- Not generally used or recognized by the medical community, physician specialty societies or licensed health care Providers practicing in the relevant clinical area, as safe, effective, and appropriate for diagnosis or treatment of a Sickness or Injury.
- Are currently in the research or Investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical research protocol or clinical trial.
- Subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational).
- Obsolete or ineffective for the treatment of a Sickness or Injury.
- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use.
- Not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information or similar compendia as appropriate for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III ca clinical trial set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight.

CareSource will make the determination if the services, at the time they are incurred, are Experimental or Investigational Services based on the criteria listed above.

This does not apply to Routine patient costs associated with clinical trials for which Benefits are available as described under ***Section 7: Covered Health Services and Limitations***.

Genetic Testing – a single test or panel of lab tests which exams blood or other tissue to look for changes or abnormalities in chromosomes, genes, or DNA. Testing can often be used to find changes associated with inherited disorders. The results may confirm or help to confirm or rule out risk for developing a specific disease, condition or help determine targeted treatments.

Grievance – any written complaint or dispute expressing dissatisfaction with any aspect of Our operations or activities or any In-Network Provider.

SECTION 2: TERMS AND DEFINITIONS – Listed alphabetically

Habilitative Services – health care services that help a person 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 services for people with disabilities in a variety of Inpatient Confinement and/or outpatient settings.

Home Health Agency – a program or organization with clinically skilled and licensed professionals authorized by law to provide health care services in the home.

Hospital – a medical facility that provides acute care or subacute medical care for a Sickness or an Injury on an Inpatient Confinement basis. This type of facility may also be referred to as a subacute medical facility or a Long- Term Acute Care facility and must meet all the following requirements:

- Be licensed by the state in which the services are rendered and accredited by an accreditation agency as determined by CareSource, including, the Joint Commission or Medicare, to provide acute care or subacute medical care.
- Be staffed by an on-duty Provider 24 hours per day.
- Provide nursing services supervised by an on-duty registered nurse 24 hours per day.
- Maintain daily medical records that document all services provided for each patient.
- Provide immediate access to appropriate in-house laboratory and imaging services.
- Not primarily provide care for behavioral health or substance abuse although these services may be provided in a distinct section of the same physical facility.
- Provide care in an intensive care unit (ICU), a neonatal intensive care unit (NICU), a coronary intensive care unit (CICU) and step-down units.

Illness – A physical or Mental disease or ailment that negatively affects a person's health**.**

Independent External Review – A review of an Appeal of an adverse determination that has been upheld by the Appeal and Grievance committee. The review is conducted by an independent review organization (IRO) via the Health and Human Services (HHS) administered external review process.

Injury – bodily damage other than due to Illness or chronic disease, including all related conditions and recurrent symptoms.

In-Network Benefits or In-Network Level of Benefits – how your health Benefits are applied to Covered Health Services rendered by an In-Network Provider including limitations and exclusions, Deductibles, Copays, Coinsurance, and Out-of-Pocket Maximums. Refer to the Schedule of Benefits for details about how In-Network Benefits apply. In-Network Benefits do not include the amount CareSource pays health care Providers. Please see the definition for Maximum Allowed Amount to understand how In-Network and Out-of-Network Providers will be paid under the Policy.

In-Network Pharmacy – a pharmacy that has entered into an agreement with Us, or an organization contracting on Our behalf, to provide Prescription Drug Products to Covered Persons and has agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.

In-Network Provider – a Provider that has a participation agreement in effect (either directly or indirectly) with Us or with an affiliate of Ours to participate in Our network.

A Provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be an In-Network Provider for only some of Our products. In this case, the

Provider will be an In-Network Provider for the Covered Health Services and products included in the participation agreement, and an Out-of-Network Provider for other Covered Health Services and products. The participation status of Providers will change from time to time.

Inpatient Confinement – admission to a Hospital, Skilled Nursing Facility, residential treatment facility, Inpatient Rehabilitation Facility or other licensed facility for a stay of at least 24 hours for which a charge is incurred for room and board.

Inpatient Rehabilitation Facility – free standing Rehabilitation Hospitals and Rehabilitation units in acute care Hospitals providing an intensive Rehabilitation program; patients who are admitted must be able to tolerate at least three hours of intense Rehabilitation services per day.

Institution of Higher Learning – a technical college; or any college or university that grants a bachelor's degree or higher.

Intensive Outpatient Treatment – a structured outpatient Mental Health and Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides evidence-based behavioral therapies that are directly based on and related to a member's therapeutic goals and skills as prescribed by a Provider familiar with that member for at least three hours per day, two or more days per week. Group therapy may not be Covered in all settings.

Intermittent Care – Skilled Nursing care that is provided or needed either:

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

Long-Term Care – refers to services which meet both the medical and behavioral needs of people with an Injury or Illness in which they have been treated with appropriate medical or therapeutic services but have already reached their maximum Benefit or are back to baseline status. Long-Term Care is not Covered under the health Plan.

Long-Term Acute Care Hospital (LTACH) – Hospitals that provide services including comprehensive Rehabilitation, respiratory therapy (including ventilator management and weaning), head trauma treatment, and severe wound management. Patients are usually transferred from an intensive or critical care unit and, on average, stay in an LTACH more than 25 days.

Maximum Allowed Amount (MAA) – the maximum amount We will pay for a Covered Health Service. For an In-Network Provider, the Maximum Allowed Amount is the agreed upon payment amount the Provider and Plan have agreed upon. An In-Network Provider is not allowed to Balance Bill above this amount for a service.

For Out-of-Network Providers, the Maximum Allowed Amount is a rate similar to what the plan would have paid had the provider/service been rendered by a contracted provider in the same geographic region for a similar service. For Out-of-Network Providers performing Emergency Health Services and/or services covered under the No Surprises Act CareSource will pay the Qualifying Payment Amount (Please see the definition for Qualifying Payment Amount for more detail. The Out-of-Network provider may be able to balance bill. See Balance Billing explanation in the definition above and in ***Section 5: How to Obtain Covered Health Services.***

Medically Necessary (or Medical Necessity) – health care services, supplies or items needed to prevent, diagnose, or treat an Illness, Injury, condition, disease or its symptoms and that meet accepted standards of medical or behavioral health care that are all the following as determined by Us or a CareSource's designee, within Our sole discretion:

- Consistent with generally accepted standards of contemporary medical consensus and medical practice for your medical condition, meaning:
    - Standards that are based on credible scientific evidence-based published in peer-reviewed, medical literature, or
    - Physician Specialty Society recommendations, or
    - The prevailing opinion of licensed health care Providers practicing in the relevant clinical area.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and provided in the most appropriate site and at the most appropriate level of service and level of care for your condition considered effective for your Sickness, Injury, Mental Illness, Substance Use Disorder, disease or its symptoms.
- Not mainly for your convenience or that of your healthcare Provider.
- The least costly of an alternative drug, service(s) or supplies that are comparably equivalent in safety and effectiveness for the diagnosis or treatment of your Sickness, Injury, disease, or symptoms.
- Provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of medical care provided.
- Not deemed Experimental, Investigative, or unproven for your condition.
- Not primarily for Cosmetic purposes or services that are provided solely to improve your physical appearance or normal and expected changes associated with aging.
- Consistent with Our clinical policies and criteria.

Generally accepted standards of medical practice are standards that are based on credible, well-designed studies and scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Provider specialty society recommendations or professional standards of care may be considered. The fact that a Health Care Provider has prescribed, ordered, recommended, or approved a treatment, service, or supply, or has informed the Member of its availability does not, in itself, make it Medically Necessary.

We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Provider specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within Our sole discretion.

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

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

Mental Illness – those Mental Health or psychiatric Diagnostic categories that are listed in the current

Diagnostic and Statistical Manual of the American Psychiatric Association.

Observation Stay – is an alternative to an Inpatient admission that allows reasonable and necessary time to evaluate and render Medically Necessary services to a member whose diagnosis and treatment are not expected to exceed 24 hours and occasionally more.

Out-of-Network Authorization– a written request from an In-Network Provider requesting services be provided to a member from an Out-of-Network Provider. An authorization will not be approved if there are In-Network Providers who can reasonably provide the same or substantially similar care or if the request is not first initiated by an In-Network Provider. ***See Section 5 under Limited Covered Health Services from Out-Of-Network Providers.***

Out-of-Network Provider/Facility/Pharmacy – a non-network Provider/facility/pharmacy is one which has not been selected for participation in CareSource's network.

Out-of-Pocket Maximum – the maximum amount you are required to pay for medical and Prescription Drugs in a single year. Amounts paid for non-Covered services, including amounts in excess of the Maximum Allowed Amount, do not count towards your Out-Of-Pocket Maximum. Any financial assistance including coupons, savings cards, grants, special programs or gift/cash cards you may receive will not be credited to your Out-Of-Pocket Maximum unless required by State and Federal law. Furthermore, when the Plan pays an Out-of-Network Provider for the limited Covered Health Services set forth under this Certificate, amounts paid in excess of the Maximum Allowed Amount do not count towards your Out-Of-Pocket Maximum. See Balance Billing explanation in ***Section 2: Terms and Definitions*** **and** ***Section 5: How to Obtain Covered Health Services.***

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program that uses evidence-based behavioral therapies that are directly based on and related to a member's therapeutic goals and skills as prescribed by a Provider familiar with that member providing services for at least 20 hours per week.

Pharmacy Benefit Manager (PBM) - 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 8 for more information about what the PBM does for you.

Plan (or We, Us, Our) – CareSource (Common Ground Healthcare) which provides Benefits to Covered Persons for the Covered Health Services described in this Certificate.

Policy – the entire agreement between you and CareSource, that includes all the following:

- This Certificate.
- The Schedule of Benefits.
- Your application.
- Amendments and Riders.
- Notices.

Practitioner/Qualified Practitioner – includes, broadly, the term healthcare "Provider", and is not limited to, a physician, physician assistant, nurse practitioner or nurse midwife, nurse anesthetist, podiatrist, psychologist, licensed clinical social worker, marriage and family therapist, optometrist, dentist,

chiropractor of physical therapists. Regarding medical services provided to a Covered Person, a Qualified Practitioner must be licensed or certified by the state in which care is rendered and must perform services within the scope of that license or certification.

Pregnancy – includes services for all of the following:

- Prenatal care (care before the baby is born) and complications associated with Pregnancy.
- Childbirth and postnatal care (care for the baby after birth).

Premium – the amount you and your Dependents are required to pay for coverage to keep the Policy in force.

Prescription Drug/Pharmaceutical Product – a drug, medication or device approved by the U.S. Food and Drug Administration (FDA) and that can, under federal or state law, only be dispensed using a Prescription by a provider within the scope of the provider's license. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of the Plan, Prescription Drugs include:

- Immunizations administered in a Pharmacy;
- Inhalers (with spacer);
- 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 List – a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to -periodic review and modification (generally quarterly, but no more than six times per calendar year). You may find out which tier a particular Pharmaceutical Product has been assigned by calling 877-514-2442 or at CareSource.com/Marketplace.

Preventive/Routine Care – there are three types of Preventive Care an individual may receive, but only two are Covered Health Services under your Plan:

1. Benefits **include** certain Preventive Care that is Covered at 100% (no cost to Covered Person) if the care is received In-Network;
2. Benefits **include** certain Preventive Care that is not Covered at 100% that may be subject to Deductibles, Copays and Coinsurance; and
3. Benefits **do not include** Preventive Care that is not Medically Necessary or is otherwise listed as an exclusion.

Preventive Care may also be called Routine Care and is provided on an outpatient basis at a Primary Care Provider's office when there is not a health or medical concern present. Any medical concerns you discuss with your Primary Care Provider may result in tests that would be considered Diagnostic and not Preventive and may be subject to Deductibles, Copays and Coinsurance.

Primary Care Provider – a Provider, a physician's assistant, or advanced practice nurse, including group

practice who has devoted a majority of his or her practice to general pediatrics, internal medicine, obstetrics/gynecology, family medicine, general medicine or geriatrics.

Prior Authorization – the determination of coverage for Covered services and procedures which are made after review of the advanced, written authorization, with appropriate documentation for specific medical services or treatments. Prior Authorization is determined based on Medical Necessity as outlined in this Certificate. Services requiring Prior Authorization are specified in the Prior Authorization list which is available by calling Member Services at 817-514-2442 or by viewing it on our website at CareSource.com/mp-WI-pa. Failure to obtain Prior Authorization when required will result in application of the penalty listed in ***Section 6: Prior Authorization & Hospital Admission Notification***.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an Inpatient Confinement or home setting when any of the following are true See ***Section 9: Exclusions***:

- No skilled services are identified.
- Skilled Nursing resources are available in the facility.
- Skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family.

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

Note: Any podiatrist, psychologist, chiropractor, optometrist, clinical social worker, marriage and family therapist, nurse Practitioner, professional counselor or other Provider who acts within the scope of his or her license will be considered on the same basis as a Provider. The fact that CareSource describes a Provider as a Provider does not mean that Benefits for services from that Provider are available to you under the Policy.

Qualifying Payment Amount (QPA) – the payment amount for a particular item or service calculated in accordance with 45 CFR § 149.140.

Rehabilitative Services – health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric Rehabilitation Services in a variety and/or outpatient settings.

Rescission of Coverage – a decision by an insurer to terminate an insurance Policy back to the initial date of coverage, change the terms of the Policy, or change the Premium by more than 25%. It is not a rescission if the Premium changes based on the age of the member or applicant or if the rate change is applied uniformly to all similar individual Policies.

Rider – any attached written description of additional Covered Health Services not described in this Certificate. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are Effective only when signed by CareSource and are subject to all conditions, limitations, and exclusions of the Policy except for those that are specifically amended in the Rider.

Schedule of Benefits – the document that accompanies this Certificate and lists the Benefits and the Benefit limitations Covered under the Policy.

Semi-Private Room – a room with two or more beds.

Service Area – the geographic area We serve and has been approved by the appropriate regulatory agency. The Service Area may change from time to time. Contact Us to determine the exact geographic area We serve. A complete listing of the counties included in the Service Area can be found at CareSource.com/marketplace.

Sickness – physical Illness or disease.

Skilled Nursing Facility – a facility that is licensed and certified to provide continuous, 24-hour Inpatient Skilled Nursing Services, which operates as required by law, and as appropriately accredited as determined by CareSource. None of the following are a Skilled Nursing Facility:

- An institution that primarily cares for and treats individuals with behavioral health or Substance Use Disorders.
- A facility that primarily provides residential, retirement, Custodial or Long-Term Care.
- A private room or apartment.

Skilled Nursing Services – services ordered by a Physician that:

- Require the skills of a registered nurse (RN) or a licensed practical nurse (LPN); and
- Are provided either directly by or under the supervision of an RN or LPN.

Skilled Rehabilitation Facility – a licensed facility that is certified to provide continuous, 24-hour Inpatient Skilled Rehabilitation care. It can be a separate Rehabilitation unit of a Hospital, a freestanding special Rehabilitation Hospital, or other health care institution.

Skilled Rehabilitation Services – services ordered by a Physician that:

- Require the skills of a licensed physical therapist, occupational therapist, speech pathologist, speech-language pathologist, audiologist, or respiratory therapist; and
- Are provided either directly by or under the supervision of these qualified Skilled Rehabilitation personnel.

Special Enrollment Period – a time outside the yearly Open Enrollment Period when you can sign up for health insurance. You qualify for a Special Enrollment Period if you have had certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child.

Specialty Care Provider – a Provider, physician's assistant, or advanced practice nurse, including group practice who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family medicine, general medicine or geriatrics.

Specialty Prescription Drug Product – a Prescription Drug Product that that is generally a high-cost, self-administered biotechnology drug used to treat patients with certain Illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at CareSource.com/marketplace or by calling 817-514-2442.

Student – a person attending an accredited vocational, technical, adult education school or college on a full-time basis consisting of a minimum of 12 credit hours per semester.

Subscriber – an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the individual.

Substance Use Disorder Services – Covered Health Services for the diagnosis and treatment of alcoholism and Substance Use Disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service. For the purposes of this Certificate, the term substance abuse has the same meaning as substance use.

Telehealth Service – a Telehealth Service is a virtual visit/appointment with a qualified healthcare Provider who uses an audio-video or audio-only telecommunication system to communicate with their patients and offer safe alternative solutions for care and provides convenient access.

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

Total Disability or Totally Disabled – a Subscriber's inability to perform all the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Behavioral Health Care – Mental Health Services and Substance Use Disorder Services that are provided in a less restrictive manner than Inpatient Hospital services, but more intensive than outpatient services. Services are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. These arrangements may be used with ambulatory treatment when treatment alone does not offer the intensity/structure needed to assist with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide Covered Persons with stable and safe housing and the opportunity to learn how to manage their Activities of Daily Living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment does not offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) – services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. For a service, including medications, to be considered proven, they must meet the following criteria:

- Be supported by 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).
- Be supported by well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group).

We have a process to compile and review clinical evidence with respect to certain health services. From

time to time, We issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice.

Urgent Care – treatment or services provided for a Sickness or Injury that develops suddenly and unexpectedly that requires immediate treatment but is not of severity to be considered Emergency treatment.

Urgent Care Center – a facility that provides for the delivery of Urgent Care services and that generally provides unscheduled, walk-in care. An Urgent Care Center is not a regular Provider office, an Emergency room, or a Hospital.

SECTION 3: MEMBER RIGHTS AND RESPONSIBILITIES

This section includes information on:

- **Member rights**
- **Member responsibilities**
- **Your Premium**
- **CareSource's responsibilities**

All members should understand their rights and their responsibilities as members of a non-profit health insurance cooperative where members have a financial stake in the decisions they make.

MEMBER RIGHTS

All CareSource members have the right to:

1. Receive information about Us, Our services, Our Practitioners and Providers and member rights and responsibilities.
2. Be treated with respect and dignity by CareSource employees and its contracted health care Providers and professionals. Please know We will not discriminate in the service or Benefits offered to you based on race, color, national origin, sex, age, or disability.
3. Have privacy of medical and financial records maintained by CareSource and its health care Providers in accordance with existing law.
4. Be informed about Medically Necessary, appropriate and/or alternative treatment options and their risk, regardless of cost or Benefit coverage.
5. Participate with health Practitioners in making decisions about your health care and treatment.
6. Voice Complaints or concerns about CareSource or any of its In-Network Providers and contracted vendors.
7. Appeal any decision made by CareSource and to receive a response within a reasonable amount of time.
8. Make recommendations regarding Our Member Rights and Responsibilities Policy.
9. Choose an advance directive to designate the kind of care you wish to receive should you become unable to express your wishes.
10. Have a safe, secure, clean and accessible health care environment.
11. Have access to Emergency health care services in cases where a "prudent layperson" acting reasonably would believe that an Emergency existed.

MEMBER RESPONSIBILITIES

All CareSource members have the responsibility to:

1. Pay your Premiums. You must make Premium payments to CareSource by the specified due date for you to remain enrolled and receive Benefits. Your Premium is due on the 25th of the preceding month that you will receive coverage. For example, premium due on May 25 is for coverage throughout the month of June. More information about grace periods and Premium payment

follows on the next page under "Your Premium".

2. Comply with all provisions of the Policy outlined in the Certificate of Coverage, including seeing In-Network Providers, and obtaining Prior Authorization when required.
3. Know and confirm your Benefits before receiving treatment. Call Our Member Services department if you have questions about this.
4. Show your ID card before receiving health care services. Showing your ID card will help ensure timely and accurate submission of your Claims.
5. Pay your share of your care by paying applicable Copayments, Deductibles and/or Coinsurance to participating Practitioners and Providers when services are received for most Covered Health Services. These payments are due at the time of service or when billed by the In-Network Provider.

   Note**:** Deductible, Copayment and Coinsurance amounts are listed in the Schedule of Benefits. Under limited circumstances when CareSource pays an Out-of-Network Provider listed in the Limited Covered Health Services for Out-of-Network Providers, you may also be Balance Billed by the Out-of-Network Provider. When this happens, you are required to pay any amount that exceeds the CareSource Maximum Allowed Amount. Also see Balance Billing explanation in ***Section 2: Terms and Definitions and Section 5: How to Obtain Covered Health Services***.
6. Follow care instructions as directed by your Provider and pharmacist to obtain your optimal level of health.
7. Decide on what services you should receive. Decisions on your care are between you and your Providers. CareSource does not make the decision about the kind of care you should or should not receive. If you choose to receive care that is not a Covered Health Service, or does not meet the Medical Necessity language, you may have to pay the entire cost of that care.
8. Understand your personal health conditions and develop mutually agreed upon treatment goals with your care team, to achieve and maintain your optimal health. If you would like help developing questions to discuss with your Provider, Our clinical team has a care manager and social worker who will be happy to assist you.
9. Provide accurate information, to the extent possible, so your Practitioner may properly care for you, which allows for CareSource to make an informed determination of how to apply your Benefits.
10. Use Practitioners and Providers affiliated with the CareSource network for health care Benefits and services, except where services are allowed by an approved Out-of-Network Authorization from your health Plan, or in the event of an Emergency. It is your responsibility to select the network health care professionals who will deliver care to you. Please visit Our website at findadoctor.caresource.com or call Us at 877-514-2442 to make certain the doctor you select is in Our network. The availability of Providers in Our network is subject to change. You may find that a particular In-Network Provider is not accepting new patients or has left the network. If a Provider leaves the network or is otherwise not available to you, you must choose another In-Network Provider to receive Benefits under the Policy, except as indicated in the Continuity of Care section of this Certificate.
11. Pay full charges for all excluded services and items.
12. Provide Us with written notice about losses/Claims. Generally, your Provider will send Us Claims for treatment you receive. Technically, this is your responsibility. If written proof of loss is not

received by Us within one (1) year from the time otherwise proof is required, We may reject your Claim. The Claims submitted by your Providers will usually be sufficient for Us to process the Claims. Sometimes, We may need additional information from you, your Provider or a third party to determine Our liability. We may need you to assist in getting Us the needed information. If We are not able to obtain the necessary information, your Claim may be denied.

YOUR PREMIUM

Except for annual changes your Premium is based on your age. We generally will not change Premium unless the Premium of everyone We issued the Policy in Our Service Area changes. If We increase the Premium by more than 25%, We will provide you with 60 days prior written notice.

Many people receive an Advance Premium Tax Credit (APTC) from the federal government that lowers the amount they pay toward their monthly health insurance Premium payment. CareSource receives this tax credit directly from the Federal government for most of Our members, and then adjust the amount owed on monthly invoices. If you lose eligibility for an APTC, or your APTC changes, We will receive notice from the Federal government and the amount you owe for Premium will change. These determinations are made by the Federal Marketplace (otherwise known as Healthcare.gov) and not by Us. If you have a question regarding your APTC, please contact the Federal Marketplace at 800-318-2596.

All members have a grace period for paying Premiums. The length of the grace period depends on whether you are eligible for an APTC as follows:

- **You do not receive an APTC = 31 days.** If you do not receive an Advance Premium Tax Credit (APTC) that lowers the amount you pay toward your monthly coverage, and you fail to pay the Premium within 31 days after the due date, your coverage will terminate as of the last day of the last month for which We received the Premium. When mailing your payment, please allow up to seven days for it to be received and processed. You are not considered to have paid your Premium until CareSource receives your payment.
    - For example, your Premium for the month of May is due by April 25. If your Premium is not received and processed by April 30, you will be notified that you have fallen into grace and are no longer eligible for Benefits. If you fail to pay your Premium and come out of grace prior to May 31, your coverage will be terminated back to April 30.
- **You receive an APTC = 3 months.** If you receive an Advance Premium Tax Credit (APTC) and you fail to pay your Premium when due, you are given a three-month grace period which begins on the first day of the coverage month for which the Premium was not received. If full payment of all billed Premiums are not received by the end of the grace period, your coverage will terminate as of the last day of the first month of the three-month grace period as outlined on your invoice. When mailing your payment, please allow up to seven days for it to be received and processed. You are not considered to have paid your Premium until We receive your payment.
    - For example, your Premium for the month of May is due by April 25. If your Premium is not received and processed by April 30, you will be notified that you have fallen into grace and your Benefits will cease as of May 31 if you do not pay your outstanding Premium before your grace period is exhausted. If you fail to pay your Premium and fully come out of grace prior to July 31, your coverage will be terminated back to May 31.

If you make a payment for any period in which your Policy is not active (for example, you make a payment on a terminated or non-effectuated Policy), CareSource will return your payment less any Claims paid for any period during which your Policy was not active. CareSource's acceptance of the Premium does not

constitute an activation or continuation of a Policy.

CARESOURCE'S RESPONSIBILITIES

1. Determine Benefits. CareSource makes administrative decisions regarding whether the Policy will reimburse for any portion of the cost of a health care service you intend to receive or have received. CareSource's determinations are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your Providers must make those treatment decisions. We may establish reasonable quantity limits for certain supplies, equipment or appliances as described below.

   In determining Benefits, We will do the following:
   - Apply Benefits, to Claims reviewing Provider status in the network, authorizations, limitations and exclusions set out in this Certificate, the Schedule of Benefits, and any Riders and/or Amendments.
   - Make determinations relying on clinical criteria for application of Benefits based on facts.
   - Supply you the results of said determinations following state and federal regulations.
2. We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Certificate, such as a pharmacy Benefits administrator. The identity of the service Providers and the nature of their services may be changed from time to time at Our discretion. To receive Benefits, you must cooperate with those service Providers.
3. Contract with Health Care Providers: We arrange for Providers and other health care professionals and facilities to participate in CareSource's Provider network. Our Provider network is subject to change at any time. Please contact Us at 877-514-2442 to check on the availability of an In-Network Provider. To find Providers, please visit findadoctor.caresource.com.
4. Our credentialing process confirms public information about the professionals and facilities licenses and other credentials but does not assure the quality of their services. These professionals and facilities are independent Practitioners and entities that are solely responsible for the care they deliver.
5. Pay In-Network Providers. When you receive Covered Health Services from In-Network Providers, you should not have to submit a Claim to Us.
6. Out-of-Network Providers. We will pay Out-of-Network Providers only in limited circumstances as specified in the limited Covered Health Services from Out-of-Network Providers provision.
7. Review/determine Benefits in accordance with Our reimbursement policies. We develop reimbursement policy guidelines, in Our sole discretion, in accordance with one or more of the following methodologies:
   - As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
   - As reported by generally recognized professionals or publications.
   - As used by Medicare.
   - As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that CareSource accepts.

Once a Claim is received, We will review the Claim for accuracy and validity (e.g., correct coding, billing errors, abuse and fraud reviews). After that, Our reimbursement policies are applied consistently across

Our membership to all Provider Claims. We will determine the Eligible Expenses and Maximum Allowed Amount. We share the reimbursement policies with In-Network Providers. In-Network Providers may not Balance Bill you for the difference between their contract rate and the billed charge. Out-of-Network Providers may Balance Bill you. ***See Balance Billing explanation in Section 2: Terms and Definitions and Section 5: How to Obtain Covered Health Services.***

SECTION 4: WHEN COVERAGE BEGINS AND ENDS

This section includes information on:

- **Enrollment in the Plan**
- **When coverage begins**
- **When coverage ends**

HOW TO ENROLL

Eligible Persons must complete an application. You may apply through the Federal Health Insurance Marketplace or Healthcare.gov, called "the Marketplace". You may also obtain an application directly from Us or from a health insurance Agent that is appointed to sell CareSource Policies. We will not provide Benefits for health services that you receive before your Effective Date of coverage.

ELIGIBILITY FOR COVERAGE

If you apply for coverage through the Marketplace, the Marketplace will determine whether you are eligible to enroll under the Policy and who qualifies as a Dependent. If you apply directly with Us, then We determine who is eligible to enroll under the Policy and who qualifies as a Dependent.

When an Eligible Person enrolls, We refer to that person as a Covered Person or member. For a complete definition of Eligible Person and member, see ***Section 2: Terms and Definitions***. Eligible Persons must reside within Our Service Area.

DEPENDENT

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, We refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, **see *Section 2: Terms and Definitions***.

WHEN TO ENROLL AND WHEN COVERAGE BEGINS

Eligible Persons can only enroll as follows:

- **During an Open Enrollment Period:** Eligible Persons can enroll themselves and their Dependents during the annual Open Enrollment Period as defined by the Centers for Medicare & Medicaid Services (CMS). The first date of your coverage (Effective Date) is dependent on when you enroll. Your Effective Date can be found on your ID card. You do not have coverage until the day of your Effective Date.
- **During a Special Enrollment Period:** An Eligible Person and/or Dependent may also be able to enroll during a Special Enrollment Period. Special Enrollment Periods are triggered by qualifying life events (QLE) as determined under state and Federal law. Some examples of QLEs are birth or adoption of a child, marriage, divorce, loss of employer sponsored coverage, and death of a spouse. Your eligibility to enroll and the Effective Date of your coverage depends on the type of QLE. For details on how to enroll due to a QLE, contact CareSource at 855-494-2667.

For newborns, We must receive notification of the birth and any required Premium within 60 days after the date of birth. If you fail to notify Us and do not make any required payment beyond the 60-day period, coverage will not continue, unless you make all past due payments with the applicable state allowable interest rate, within one year of the child's birth. In this case, Benefits are retroactive to the date of birth. If you have a Marketplace plan, you must add Dependents, including newborns, through the Marketplace. The Marketplace rules will govern whether a Dependent can be added.

IF YOU ARE HOSPITALIZED WHEN YOUR COVERAGE BEGINS

If you are Inpatient in a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility on the day your coverage begins, We will pay Benefits for Covered Health Services received on or after your first day of coverage if you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract. You must notify Us of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible.

IF YOU ARE ELIGIBLE FOR MEDICARE

To the extent allowed by state and federal law, your Benefits under the Policy will be reduced if you are enrolled in Medicare. Your Benefits under the Policy will also be reduced if you are enrolled in a Medicare Advantage (Medicare Part C) Plan but fail to follow the rules of that Plan.

Please see Medicare Eligibility in ***Section 10: Coordination of Benefits*** for more information about how Medicare may affect your Benefits.

GENERAL INFORMATION ABOUT WHEN COVERAGE ENDS

CareSource may discontinue coverage under this Certificate and Policy at any time for the reasons explained in this section, as permitted by law. You and your Dependents' entitlement to Benefits automatically end on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, We will pay Claims for Covered Health Services that you receive before the date on which your coverage ended. We will not pay Claims for any health services received after your termination date, even if the medical condition that is being treated occurred before the date your coverage ended.

EVENTS ENDING YOUR COVERAGE

For the events listed below, the Effective Date of the termination is specified. If more than one category is applicable, your coverage will end on the earliest of the dates.

1. **You Fail to Pay Premiums**
   If you receive an Advance Premium Tax Credit (APTC) and you fail to pay in full all Premiums due within three months of the date they are due, then We may terminate your coverage as of the last day of the first month of the applicable grace period. In all other cases, if you fail to pay Premiums within 31 days after the date they are due, then We may terminate your coverage as of the last day of the last month for which We receive Premiums.

2. **Fraud or Intentional Misrepresentation of a Material Fact**
   You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent, or submission of false, misleading or fraudulent Claims or documentation related to Claims.

   During the first two years the Policy is in effect, We have the right to demand that you pay back all Benefits We paid to you, or paid in your name, during the time you were incorrectly Covered under the Policy. After the first two years, We can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

3. **The Entire Policy Ends**
   Your coverage ends on the date the Policy (including your Certificate) ends.

4. **You Are No Longer Eligible**
   Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to ***Section 2: Terms and Definitions*** for complete definitions of the terms "Eligible Person", "Subscriber", "Dependent" and "Enrolled Dependent". If a Dependent reaches age 26 in a calendar year, his/her eligibility will end on the last day of the calendar year in which he/she reaches age 26. He or she can apply for coverage under his or her own Policy when Dependent coverage ends. This section may not apply to certain children with disabilities as described below.

5. **You Move Out of the Service Area**
   Your coverage ends 60 days following a move out of Our Service Area. This includes moves out of state, as well as those within Wisconsin if they are out of Our Service Area. You are eligible for a Special Enrollment Period to obtain new coverage through another insurance company.

6. **CareSource Receives Notice to Voluntarily End Your Coverage**
   If you enrolled through the Marketplace, your coverage ends on the date requested in the notice from the Marketplace. If you enrolled directly with Us, then your coverage ends no sooner than the date We receives your request to end your coverage. We will grant next-day or prospective coverage termination dates based on the date of your request.

COVERAGE FOR A DISABLED DEPENDENT CHILD

Coverage for an unmarried Enrolled Dependent child who is disabled will not end because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of Mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish Us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before We agree to this extension of coverage for the child, We may require that a Provider chosen by Us examine the child. We will pay for that examination.

We may ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at Our expense. However, We will not ask for this information more than once a year, after the two-year period immediately following the time the child reaches the limiting age.

If you do not provide proof of the child's disability and dependency within 31 days of Our request as described above, coverage for that child will end.

SECTION 5: HOW TO OBTAIN COVERED HEALTH SERVICES

This section includes information on:

- **Network services and benefits**
- **Provider network – In Network and Out of Network Providers**
- **Out of Network Authorization**
- **Emergency Health Services**
- **Show your ID Card**
- **Continuity of care**

The Certificate of Coverage and the Schedule of Benefits are your primary source for accurate information about your Benefits. If you have been provided any other summaries, the Certificate of Coverage and Schedule of Benefits will control.

In-Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Health Services from In-Network Providers. **Services you obtain from any Provider other than an In-Network Provider are considered out-of-network services and are NOT Covered, unless otherwise indicated in this Certificate.**

You are responsible for making sure your Provider, including laboratories, imaging or Diagnostic centers, surgical centers and Hospitals are In-Network and that Prior Authorization has been obtained when required. See the next section, ***Section 6: Prior Authorization & Hospital Admission Notification,*** to understand which services require Prior Authorization.

NETWORK SERVICES AND BENEFITS

Covered Health Services are provided by In-Network Providers. In-Network Providers include Primary Care Providers (PCP), Specialty Care Providers other professional Providers, Hospitals, and other facility Providers who contract with CareSource to perform services for you. It is not necessary to have a PCP for this health Plan, but it is strongly recommended and beneficial for you to have this type of Provider. Your PCP knows your health history. They can assist you in obtaining appropriate Preventive Care, medication management, be a point of contact when you are sick and require medical care, as well as provide referral to specialists and care coordination. Specialty Care Providers are In-Network Providers who provide specialty medical services not normally provided by a PCP.

No Benefits will be provided for care that is not a Covered Health Service, even if performed by a licensed Provider or specialist who is an In-Network Provider. We have final authority to determine coverage eligibility for a service based upon a Medical Necessity determination.

For services rendered by In-Network Providers:

- You will not be required to file any Claims for services you obtain directly from In-Network Providers. In-Network Providers will seek compensation for Covered Health Services rendered from CareSource and not from you except for any applicable Deductible, Copayments, and/or Coinsurance. You may be billed by your In-Network Provider(s) for any non-Covered Health Services you receive or when you have not acted in accordance with this Certificate, including those that are not Medically Necessary or excluded from coverage.
- CareSource does not decide what care you need or will receive. Coverage determinations rely on this Certificate of coverage. You and your Provider need to determine what care is best for you.

SECTION 5: HOW TO OBTAIN COVERED HEALTH SERVICES

PROVIDER NETWORK

CareSource arranges for healthcare Providers to participate in a network. In-Network Providers are independent Practitioners. They are not employees. We maintain a directory of In-Network Providers at findadoctor.caresource.com. If you need assistance with finding a doctor, please call Member Services at 877-514-2442 to ensure the doctor you select is In-Network.

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

Before obtaining services, you should always verify the network status of a Provider as the status or Providers may change.

It is possible that you might not be able to obtain services from a particular In-Network Provider. Or you might find that a particular In-Network Provider may not be accepting new patients. If a Provider leaves the network or is otherwise not available to you, you must choose another In-Network Provider to get Benefits under the Policy, except as provided for in the Continuity of Care provisions of this Certificate, ***See Section 5 under Continuity of Care***.

Do not assume that an In-Network Provider's agreement includes all Covered Health Services. Some In-Network Providers contract with Us to provide only certain Covered Health Services, but not all Covered Health Services. Some In-Network Providers choose to be an In-Network Provider for only some of Our products. Please refer to your Designated In-Network Provider directory.

DESIGNATED FACILITIES AND DESIGNATED PROVIDERS

If you have a medical condition that CareSource believes needs special services, We may direct you to a Designated Facility or Designated Provider. If you require certain complex Covered Health Services for which expertise is limited, We may direct you to a network facility or Provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Provider, We may reimburse certain travel expenses at Our discretion. There are also times when We will direct you to a specific location to receive care to align with utilizing the most cost-effective method, proven safe and effective and will not negatively affect the condition of the member.

In both cases, In-Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Provider or other Provider chosen by Us.

You or your In-Network Provider must notify Us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Provider. If you do not notify Us in advance, and if you receive services from an Out-of-Network Facility (regardless of whether it is a Designated Facility) or other Out-of-Network Provider, Benefits will not be paid. ***See below, Limited Covered Health Services from Out-Of-Network Providers.***

LIMITED COVERED HEALTH SERVICES FROM OUT-OF-NETWORK PROVIDERS

There are generally no Benefits payable for treatment provided by Out-of-Network Providers. Benefits are payable only under these limited circumstances:

- Emergency Health Services performed at an Out-of-Network Facility or by Out-of-Network Providers. Once the Emergency has been stabilized, ongoing hospitalization and any follow-up care must be provided by In-Network Providers.

- Medically Necessary Urgent Care services at out of Service Area Providers when a Covered Person is traveling, or a Dependent is residing outside of the Service Area. Any follow-up care must be provided by In-Network Providers.
- A written Out-of-Network Authorization is obtained from an In-Network Provider to see an Out-of-Network Provider and the written Out-of-Network Authorization is approved by Us before services are rendered. Any services the Out-of-Network Provider recommends must comply with all provisions of the Policy, including Prior Authorization. If you fail to obtain the written, approved Out-of-Network Authorization prior to treatment, no payment will be made for those services. If the Prior Authorization is approved after services are rendered (except in cases of Emergency), the penalty listed in the Prior Authorization section will apply. ***Section 2: Terms and Definitions*** **and below Balance Billing.**
- Note: Network approval does not represent a guarantee of coverage or payment. The approval is subject to the terms of the members Certificate of coverage for the Plan purchased including but not limited to eligibility, Benefits, Medical Necessity, and Prior Authorization.
- For a Dependent Student member of your Certificate who attends an Institution of Higher Learning outside of the Service Area, but inside the State of Wisconsin, We will treat as Covered Health Services, a clinical assessment by an Out-of-Network Provider and up to five visits for outpatient behavioral health or addiction treatment. We reserve the right to select the Provider of those services. Notify Us prior to receiving treatment, or as soon as possible. See Balance Billing explanation in ***Section 2: Terms and Definitions*** **and below Balance Billing.**

BALANCE BILLING

Out-of-Network Providers may Balance Bill you for the amount over the Maximum Allowed Amount for Covered Health Services. ***Also see Section 2 for the definition of Balance Billing.***

You may be Balance Billed for Covered Health Services by an Out-of-Network Provider for:

- Ground Ambulance.
- Urgent Care.
- Non-Emergency services.
- Referrals for Out-of-Network Providers who do not come to an agreement on a payment rate.

You cannot be balanced billed for Covered Health Services by an Out-of-Network Provider for:

- Emergency services, including Covered ancillary services (examples: labs and radiology) to evaluate the Emergency medical condition. ***See Section 2 for definition of Emergency.***
- Emergency Air Ambulance.
- Covered ancillary services provided at an In-Network Facility.

Note**:** In-Network Providers cannot Balance Bill you for Covered Health Services.

OUT-OF-NETWORK AUTHORIZATION FOR OUT-OF-NETWORK PROVIDERS

If you need to seek treatment from an Out-of-Network Provider, your In-Network Provider must complete and submit an Out-of-Network Authorization that must be approved by CareSource before services are rendered. If the Out-of-Network Authorization process is not followed, Benefits will not be payable. ***See Section 5 under Limited Covered Health Services from Out-Of-Network Providers.***

Eligible Expenses are the amount We determine will be paid for Benefits subject to the Maximum Allowed

Amount as defined in ***Section 2: Terms and Definitions and Balance Billing***

For In-Network Benefits, you are not responsible for any difference between the Maximum Allowed Amount and the amount the Provider bills. You are responsible for any applicable Deductible, Copayment or Coinsurance.

For Limited Covered Health Services from Out-of-Network Providers under this Certificate, you are responsible for paying, directly to the Out-of-Network Provider, any difference between the amount the Out-of-Network Provider bills you and the Maximum Allowed Amount, and payment of any applicable Deductible, Copayment or Coinsurance. Eligible Expenses are determined solely in accordance with CareSource's reimbursement policy guidelines. See Balance Billing explanation in ***Section 2: Terms and Definitions*** **and** ***Section 5: How to Obtain Covered Health Services.***

EMERGENCY HEALTH SERVICES

In-Network Level of Benefits apply to Covered Emergency Health Services that are provided by an In-Network or Out-of-Network Provider. It is recommended you know which Emergency room is in your network to ensure any necessary follow-up care can be obtained with an In-Network Provider.

OUT-OF-SERVICE-AREA SERVICES

Benefits for medical services from Providers that are located outside of the CareSource Service Area, including those located outside of the State of Wisconsin are only payable as specified in the Limited Covered Health Services from Out-of-Network Providers provision. The only way to ensure you will not have additional amounts to pay is to stay In-Network for all Covered Health Services. See Balance Billing explanation in ***Section 2: Terms and Definitions*** **and** ***Section 5: How to Obtain Covered Health Services.***

RELATIONSHIP OF PARTIES (CARESOURCE AND IN-NETWORK PROVIDERS)

The relationship between CareSource and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees, nor are CareSource employees or agents of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Health Service under your Certificate. We are not responsible for any Claim or demand caused by damages arising out of, or in any manner connected with, any Injuries suffered by a member while receiving care from any In-Network Provider or in any In-Network Provider's facilities.

Your In-Network Provider's agreement for providing Covered Health Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs.

NOT LIABLE FOR PROVIDER ACTS OR OMISSIONS

We are not responsible for the actual care you receive from any person. This Certificate does not give anyone any Claim, right or cause of action against Us based on the actions of a Provider of health care services or supplies**.**

IDENTIFICATION CARD (ID)

You must show your ID card every time you request health care services. If you do not show your ID card, In-Network Providers have no way of knowing that you are enrolled under a CareSource Policy. As a result, they may bill you for the entire cost of the services you receive. Only a Covered Person who has paid the Premiums under this Certificate has the right to services or Benefits under this Certificate. If anyone receives services or Benefits to which they are not entitled to under the terms of this Certificate, he/she is responsible for the actual cost of the services or Benefits.

CONTINUITY OF CARE

If your Primary Care Provider was part of the CareSource network when you enrolled, but later terminates network participation without cause, you have the right to continue to access that Provider at the In-Network Level of Benefits through the end of the Policy year.

If you are undergoing a course of treatment with a Provider who is not a Primary Care Provider as defined above, and that Provider's participation in the network terminates, you have the right to continue to access that Provider at the In-Network Level of Benefits for up to 90 days, the end of your course of treatment, or the end of the Policy year whichever is shorter.

If you are Pregnant and your Provider terminates their network participation, you have the right to continue to access that Provider for your maternity care at the In-Network Level of Benefits until the completion of postpartum care.

The Continuity of Care provisions described above only apply in situations where Providers who were part of the CareSource network at the time you enrolled leave the network. They do not apply if you are switching to CareSource coverage from another health insurance company. For continuity of their care, Covered Persons new to the Plan who are in their third trimester of Pregnancy may continue to receive obstetric care from their Out-of-Network Provider through the completion of post-partum care. Covered Persons in their first or second trimester of Pregnancy at the time of initial enrollment must transition their care to an In-Network Provider.

In addition, the provisions outlined in this section are not applicable for Providers who are no longer practicing in the Service Area or who were terminated from the network for failure to meet credentialing standards.

If you wish to exercise your continuity of care rights and continue seeing your Provider for the time period specified above, please contact Member Services at 877-514-2442 so that CareSource can ensure your Claims are processed appropriately. Member Services can also assist you in selecting another In-Network Provider for your care.

SECTION 6: PRIOR AUTHORIZATION & HOSPITAL ADMISSION NOTIFICATION

This section includes information on:

- **Covered health services which require Prior Authorization**
- **Special note regarding Medicare**

Your Provider is required to get Prior Authorization on your behalf before you receive a Covered Health Service. Services requiring Prior Authorization are listed in the Prior Authorization list. It is your responsibility to ensure your Provider obtains Prior Authorization before you receive the service.

You can contact Us at 877-514-2442 to verify the status of a Prior Authorization request. Our Member Services Representatives can tell you if the Prior Authorization has been received, approved, denied or is still pending.

If your Provider fails to get a Prior Authorization, you, the member, may be responsible for a penalty of 50% up to a maximum penalty of $1,500 per Covered Health Service.

Prior Authorization is not a guarantee of Benefits. It is a determination that the services meet the definition of Medical Necessity. ***See Section 2: Terms and Definitions.*** CareSource authorizes services or supplies based on the clinical information that is submitted by the Provider at the time of the Prior Authorization request. If the bill submitted does not match the service authorized, the service may not be paid. Your Policy must be in effect at the time services are rendered.

COVERED HEALTH SERVICES WHICH REQUIRE PRIOR AUTHORIZATION

The Prior Authorization request for non-Emergency or non-urgent situations must be received by Us at least 15 business days prior to the anticipated date of your service/procedure. Please note that for urgent or Emergency admissions, Hospital admission notification must be obtained within 48 hours after the admission or as soon as medically able. Also note that a request for Hospital admission notification does not guarantee approval of services. We will notify you in writing of the decision regarding a determination for non-Emergency or non-urgent outpatient services.

If your Provider determines that additional care beyond the services specified or the length of time originally authorized is needed, you must contact Us to request that We extend the original Prior Authorization. A determination for extended time will be determined utilizing Medical Necessity criteria. You and your Provider will be notified whether the request for an extension is approved or denied.

Prior Authorization and Hospital admission notification must be obtained regardless of whether CareSource is your primary or secondary health insurance carrier unless CareSource is secondary to Medicare. Prior Authorization does not guarantee coverage.

A complete list of services requiring Prior Authorization can be found at CareSource.com/mp-WI-pa.

We encourage Our Covered Persons to take an active and informed role in their healthcare decision-making which also helps keep costs down for all Covered Persons of Our Plan.

Note: if you and/or your In-Network Provider decide on a course of treatment that is more costly or invasive then Claims may be reduced or denied. In order to meet Medical Necessity criteria, the least costly alternative service, comparable in safety and efficacy must be used for the diagnosis or treatment of your Sickness, Injury, disease, or symptoms.

SECTION 6: PRIOR AUTHORIZATION & HOSPITAL ADMISSION NOTIFICATION

As part of the interpretation of Covered Health Services in this Certificate under ***Section 2: Terms and Definitions***, We reserve the right to define clinical protocols based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness.

If you request a coverage determination when Prior Authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, the final coverage determination will be modified to account for those differences, and We will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Covered Health Service, you will be responsible for paying all charges, and no Benefits will be paid.

SPECIAL NOTE REGARDING MEDICARE

If you are enrolled in Medicare on a primary basis (Medicare pays before CareSource pays Benefits under the Policy), the Prior Authorization requirements do not apply to you. Since Medicare is the primary payer, CareSource will pay as a secondary payer as described in ***Section 10: Coordination of Benefits***. You are not required to obtain authorization before receiving Covered Health Services.

SECTION 7: COVERED HEALTH SERVICES AND LIMITATIONS

This section includes information on:

- **Covered health services**
- **Benefit limitations**

Covered Health Services and Benefits are subject to the conditions, exclusions, limitations and provisions of this Certificate, including any attachments or endorsements. Remember that this section of the document cannot be fully understood without also reading other sections of this document, including ***Section 9: Exclusions***. Benefits are available only if all the following are true:

- Covered Health Services must be Medically Necessary and not Experimental/Investigational or resulting from Experimental/Investigational clinical trials (except as described in the Clinical Trial section below). ***Section 2: under Medical Necessity.*** The fact that your Provider prescribes or recommends a service, treatment or supply does not make it Medically Necessary or a Covered Health Service and does not guarantee payment.
- Covered Health Services may include established reasonable quantity limits for certain supplies, equipment or appliances as described in this Certificate.
- Covered Health Services are received by In-Network Providers except as listed in ***Section 5 under Limited Covered Health Services from Out-of-Network Providers*** provisions.
- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received before any of the individual termination conditions listed in When Coverage Ends provision occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.
- Proper proof of loss (which mostly constitutes a Claim sent directly to CareSource from your Provider), was submitted within 90 days, but in no event, later than one (1) year from the time proof is otherwise required.

This section describes Covered Health Services for which Benefits are available. Please refer to your Schedule of Benefits (sent as part of your welcome packet) for details about:

- The amount you must pay for these Covered Health Services (including any Deductible, Copayments and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and/or dollar limits Don services and/or any maximum policy Benefit).
- Any limit that applies to the amount you must pay in a year (Out-of-Pocket Maximum).

Benefits for Covered Prescription Drugs administered in a Provider's office are subject to the terms and conditions under ***Section 7: Covered Health Services and Limitations*** of this Certificate.

BENEFIT LIMITATIONS

Please review all limits carefully, as CareSource will not pay Benefits for any of the services, treatments, items or supplies that exceed Benefit limits.

When Benefits are limited within any of the Covered Health Service categories described in this section, those limits are stated in the corresponding Covered Health Service category in the Schedule of Benefits. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the Schedule of Benefits. Additional items such as supplies, equipment, or appliances may include established reasonable quantity limits.

HOW TO USE HEADINGS IN THIS SECTION

To help you find Covered Health Services more easily, We use headings (for example, Ambulance Services below). The headings group services, treatments, items, or supplies that fall into a similar category. A description of the Covered Health Services will appear under the headings. A heading does not create, define, modify, limit, or expand Covered Health Services.

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

ADVANCED IMAGING

Advanced imaging is a Covered Benefit when performed in a Hospital or free-standing facility, including magnetic resonance imaging (MRI), computerized axial tomography (CT) and positron emission tomography PET).

AMBULANCE SERVICES

Covered Services

Covered Health Services include Emergency ambulance ground or air services, when essential to rapidly transport a member to obtain safe and effective treatment, provided by a licensed ambulance service and includes transportation to the nearest Hospital where Emergency Health Services can be performed.

Emergency ground ambulance services are provided by Out-of-Network ambulance services, which means that the services will be paid at the Maximum Allowed Amount. We will not pay charges over the Maximum Allowed Amount, and Out-of-Network Providers may decide to bill members for charges over the Maximum Allowed Amount. Also, see the Balance Billing explanation in ***Section 2: Terms and Definitions*** **and** ***Section 5: How to Obtain Covered Health Services.***

Emergency air ambulance is only Covered (at the Qualifying Payment Amount) when your health condition requires immediate and rapid ambulance transportation that ground transportation cannot provide, and one of the following applies:

- Your pickup location cannot be easily reached by ground transportation.
- Long distances or other obstacles, like heavy traffic, could stop you from getting care quickly if you traveled by ground ambulance.

Non-Emergency ground or air ambulance transportation between medical facilities is Covered when you are confined in a facility that cannot provide the appropriate level of care and you need medical attention during transportation. Transportation must meet Medical Necessity criteria.

Out-of-Network Air Ambulance Providers may not Balance Bill members for charges over the Qualifying Payment Amount if the transport was for Emergency to the Hospital.

ANESTHESIA SERVICES

Medical Services

Coverage includes anesthesia services provided in connection with medical Covered Health Services.

Dental Services

Anesthesia for Covered dental care is considered a Covered Health Service if any of the following apply to the Covered Person:

- has a chronic disability requiring hospitalization or general anesthesia for dental care.
- has a medical condition requiring hospitalization or general anesthesia for dental care.
- is a child under the age of 5.

AUTISM SPECTRUM DISORDER SERVICES

The following definitions apply for purposes of Autism Spectrum Disorders:

Intensive Level Services means evidence-based behavioral therapies that are designed to help an individual with Autism Spectrum Disorder overcome the cognitive, social and behavioral deficits associated with that disorder. Intensive level services may include evidence-based speech therapy and occupational therapy provided by a qualified therapist when such therapy is based on, or related to, an individual's therapeutic goals and skills, and is concomitant with evidence-based behavioral therapy.

Non-Intensive Level Services means evidence-based therapy that occurs after the completion of treatment for intensive level services and that is designed to sustain and maximize gains made during treatment with intensive level services or, for an individual who has not and will not receive intensive level services, evidence-based therapy that will improve the individual's condition.

Intensive level and non-intensive level services include, but are not limited to, speech, occupational and behavioral therapies. Covered Health Services include the following:

Intensive Level Autism Services

Note**:** Benefits for intensive-level services begin at the time the diagnosis is made.

Benefits are provided for evidence-based behavioral intensive level therapy for an insured with a verified diagnosis of Autism Spectrum Disorder, the majority of which shall be provided to the enrolled member when the member is present and engaged. The prescribed therapy must be consistent with all the following requirements:

- Based upon a treatment plan developed by an individual who at least meets the requirements of a qualified intensive level Provider or a qualified intensive level professional that includes at least 20 hours per week over a six-month period of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require that the enrolled member be engaged in the intervention.
- Implemented by qualified Providers, qualified professional, qualified therapists or qualified paraprofessionals.
- Provided in an environment most conducive to achieving the goals of the Enrolled member's treatment plan.
- Included training and consultation, participation in team meetings and active involvement of the Enrolled member's support system (if any) and treatment team for implementation of the therapeutic goals developed by the team.
- Commenced after the member is two years of age and before the Member is nine years of age, though exceptions outside of this age range are allowed based on Medical Necessity.
- The Enrolled member is directly observed by the qualified intensive level Provider or qualified intensive level professional at least once every two months.
- Treatment may begin after the Enrolled member is diagnosed with an Autism Spectrum Disorder.

Intensive level services will be Covered for up to four cumulative years. We may credit any previous

intensive level services the Enrolled member received against the required four years of intensive level services regardless of payer. We may also require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the Covered Person received for Autism Spectrum Disorders that was provided to the Enrolled member.

Evidence-based behavioral therapy that was provided to the Enrolled member for an average of 20 or more hours per week over a continuous six-month period is considered intensive-level services.

Travel time for qualified Providers, supervising Providers, professionals, therapists, paraprofessionals or behavioral analysts is not included when calculating the number of hours of care provided per week.

We require progress be assessed and documented throughout the course of treatment. CareSource may request and review the Enrolled member's treatment plan and the summary of progress on a periodic basis.

We will cover services from a qualified therapist when services are rendered along with intensive level evidence-based behavioral therapy and all the following apply:

- The qualified therapist provides evidence-based therapy to a member who has a primary diagnosis of an Autism Spectrum Disorder.
- The Enrolled Dependent child is actively receiving behavioral services from a qualified intensive level Provider or qualified intensive level professional.
- The qualified therapist develops and implements a treatment plan consistent with their license and this section.

Non-Intensive Level Autism Services

Non-intensive level services will be Covered for a member with a verified diagnosis of Autism Spectrum Disorder for non-intensive level services that are evidence-based and are provided to the member by a qualified Provider, professional, therapist or paraprofessional in either of the following conditions:

- After the completion of intensive level services and designed to sustain and maximize gains made during intensive level services treatment.
- To a member who has not, and will not, receive intensive level services, but for whom non-intensive level services would improve the enrolled member's condition.

Benefits will be provided for evidence-based therapy that:

- Is based upon a treatment plan developed by a qualified Provider, professional or therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured, and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require that the Enrolled Dependent child be present and engaged in the intervention.
- Is implemented by qualified Providers, professionals, therapist, or paraprofessionals.
- Is provided in an environment most conducive to achieving the goal of the Enrolled member's treatment plan.

Includes training and consultation, participation in team meetings, and active involvement of the Enrolled member in his or her therapy and active involvement is offered to the insured's family. Is provided by qualified Providers, professionals, Therapists, and paraprofessionals.

Non-intensive level services may include direct or consultative services when provided by qualified Providers, supervising Providers, professionals, paraprofessionals, or therapists.

CareSource requires progress be assessed and documented throughout the course of treatment. We may request and review the Enrolled member's treatment plan and the summary of progress on a periodic basis.

Travel time for all credentialed, qualified Providers, is not included when calculating the number of hours of care provided per week.

Limitations and Exclusions
The following Autism Spectrum Disorder services are not Covered Health Services or have limitations under the Policy:

- Any treatments or other specialized services designed for Autism Spectrum Disorder that are not supported by credible research demonstrating that the services or ancillary supplies have a measurable and beneficial health outcome and would therefore be considered Experimental, Investigational or Unproven.
- Tuition for services that are school based for children and adolescents under the Individuals with Disabilities Education Act.
- Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder.
- Treatments for the primary diagnosis of learning disabilities, and Mental Illnesses that will not substantially improve beyond the current level of functioning according to prevailing national standards of clinical practice, as reasonably determined by Us.
- Therapy, treatment or services when provided to an Eligible Person who is residing in a residential treatment center, Inpatient treatment or Day Treatment facility.
- The cost for the facility or location or for the use of a facility or location when treatment, services or evidence-based therapy are provided outside an Eligible Person's home.
- The travel time for clinical Providers. Services rendered where Intellectual Disability is the primary diagnosis as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Services which are not evidence-based
- Acupuncture
- Animal-based therapy including hippotherapy
- Auditory integration training
- Chelation therapy
- Childcare fees
- Cranial sacral therapy
- Custodial or respite care
- Hyperbaric oxygen therapy
- Services which duplicate those provided by the member's school system
- Special diets or supplements
- Travel time
- Pharmaceuticals and Durable Medical Equipment
- Therapy, treatment, or services, including room and board, provided to an Eligible Person who is staying in a residential treatment center, Inpatient treatment or Day Treatment facility
- Costs for the facility or location, or for the use of a facility or location, when treatment, therapy or services are provided outside of an Eligible Person's home
- Claims CareSource has determined are fraudulent

Note**:** The exclusion(s) do not apply if the services are provided as the result of an Emergency detention, commitment or court order as required under Wisconsin Statutes Section 609.65, Coverage for Court-Ordered Services for the Mentally Ill.

BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Covered Services

Coverage includes Benefits for Mental Health Services including those received as an Inpatient or on a Transitional Behavioral Health Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a Provider's office and performed by a licensed, In-Network Mental Health professional, or those In-Network services received via Telehealth, online, or video visits. Benefits for Mental Health Services include:

- Mental Health evaluations and assessments.
- Diagnostic testing.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient care.
- Partial Hospitalization.
- Day Treatment.
- Intensive Outpatient Treatment.
- Services at a residential treatment facility.
- Individual, family and group therapeutic services.
- Crisis intervention.

Substance Use Disorder Services include those received in an Inpatient or on a Transitional Behavioral Health Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a Provider's office, via Telehealth or at an Alternate Facility. Benefits for Substance Use Disorder Services include:

- Substance Use Disorder and chemical dependency evaluations and assessments.
- Diagnosis and treatment planning.
- Detoxification.
- Inpatient services.
- Partial Hospitalization.
- Day Treatment.
- Intensive Outpatient Treatment.
- Services at a residential treatment facility.
- Referral services.
- Medication management, including Medication-Assisted Therapy (MAT) or methadone maintenance.
- Individual, family and group therapeutic services.
- Crisis intervention.

Limitations and Exclusions

The following services are not Covered Health Services under the Policy:

Note**:** The exclusion(s) below do not apply if the services are provided as the result of an Emergency Detention, Commitment or Court Order as required under Wisconsin Statutes Section 609.65, Coverage for Court-Ordered Services for the Mentally Ill.

Behavioral Health and/or Substance Use Disorders

- Treatment for Behavioral issues unrelated to a clinical Mental Health diagnosis.
  Examples include, but are not limited to:
  - Antisocial behavior.
  - Uncomplicated bereavement.
  - Codependency.
  - Occupational problems such as job dissatisfaction or uncertainty about career choices.
  - Parent-child problems such as impaired communication or inadequate discipline.
  - Marital problems.
  - Other interpersonal problems.
- Services as treatments for conditions which may have a negative impact on Mental Health but are not associated with a Mental Health diagnosis.
- Services that extend beyond the period necessary for evaluation, diagnosis, and the application of evidence-based treatments or crisis intervention to be effective.
- Inpatient, residential or transitional treatment that continues after said treatment no longer meets Medically Necessity criteria. This includes, but is not limited to, patients awaiting placement in or transfer to another facility or level of care.
- Wilderness and camp programs, boarding schools, life coaching, and academy-vocational programs.
- Custodial or Long-Term Care.
- Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.
- Treatments for academic problems in the absence of a diagnosed Mental Health Illness, which the school may be legally obligated to provide. This applies whether the school provides these services, or you choose to provide these services. Examples include but are not limited to, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practices.
- Tuition for or services that are school based for children and adolescents under the Individuals with Disabilities Education Act.
- Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Psychological testing and assessments that are not likely to yield additional information that is useful for ongoing medical treatment. Examples include but are not limited to testing to assist with custody placement, vocational assessments, and academic assessments.
- Mental retardation with Autism Spectrum Disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Treatment provided in connection with or to comply with involuntary commitments including residential treatment for the sole purpose of preventing relapse, for legal purposes, or for family or caregiver respite.
- Services related to, or for the treatment of, compulsive gambling or nicotine addiction, except as described under this Plan's "Tobacco Cessation Benefit".
- Behavioral or Mental Health Services for, or connected to, developmental delays (e.g., Rett Syndrome).
- Therapeutic light box therapy is only Covered for seasonal affective disorder when Medical

Necessity criteria are met. All other uses of light box therapy is excluded from coverage.

- Services or supplies for the diagnosis or treatment of Mental Illness that, in Our reasonable judgment, are any of the following:
    - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
    - Not consistent with services backed by credible research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
    - Experimental or Investigational.
    - Typically, do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
    - Not consistent with CareSource's level of care guidelines or best practices as modified from time-to-time.
    - Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, Substance Use Disorder or similar condition based on generally accepted standards of medical practice.

BIOFEEDBACK

Biofeedback is a method of learning to voluntarily control certain body functions such as heartbeat, blood pressure, and muscle tension with the help of a special machine. This method can help control pain and other symptoms not ordinarily managed by other treatment methods, including medications. Biofeedback services should be provided by a physical therapist or a certified Mental Health or substance abuse professional.

Covered Health Services include biofeedback for the treatment of:

- Migraine.
- Spastic Torticollis.
- Urinary Incontinence.

Limitations and Exclusions

The following service is not a Covered Health Service under the Policy:

- Biofeedback for Temporomandibular Disorder (TMD) treatment is unproven, and therefore a non-Covered service.

BOTULINUM TOXIN (BOTOX®) INJECTIONS

Coverage includes Covered Health Services for the use of botulinum toxin primarily when provided for the treatment of disorders associated with certain Medically Necessary, non-Cosmetic reasons such as spasticity or dystonia.

Limitations and Exclusions

The following service is not a Covered Health Services under the Policy:

- Botox for Hyperhidrosis.

BREAST RECONSTRUCTIVE PROCEDURES

Covered Services

Coverage includes breast reconstructive procedures when the procedure's primary purpose is to treat a medical condition or improve or restore physiologic function. Reconstructive procedures include surgery or other procedures associated with an Injury, Sickness or Congenital Anomaly when the primary result of the procedure is not a changed or improved physical appearance.

Reconstructive procedures including breast reconstruction following mastectomy, including the non-affected breast to achieve symmetry and nipple and areola reconstruction/tattoo. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact Us at 877-514-2442 for more information.

Limitations and Exclusions

- The following service is not a Covered Health Service under the Policy: Breast augmentation not related to a prior breast cancer diagnosis.

CHIROPRACTIC SERVICES

Covered Services

Coverage includes chiropractic treatments provided by a Doctor of Chiropractic medicine when Medically Necessary and rendered within the scope of the chiropractic license, including Diagnostic testing, manipulations and treatment. The need for treatment must have resulted from Injury or Illness and must be reasonably expected to cure or alleviate your Illness or Injury or restore a functional ability to its status prior to Injury or Illness.

Limitations and Exclusions

The following services are not Covered Health Services under the Policy:

- Services for maintenance or Long-Term Care.
- Supplies such as vitamins, herbs, nutritional supplements, cervical pillows, shoes, heel lifts, orthopedic devices and lumbar rolls, unless required by law.

CLINICAL TRIALS

Covered Services

Routine patient care costs that would otherwise be Covered under this health Plan incurred during participation in an in-network qualifying clinical trial are Covered Benefits, including services related to the clinical trial such as laboratory, radiologic, and any other testing necessary to monitor the trial.

To qualify, you must be eligible to participate in the qualified clinical trial according to the trial protocol concerning the treatment of cancer or other life-threatening diseases or conditions, and either (a) the referring participating Provider has concluded that your participation in the qualified clinical trial is appropriate according to the trial protocol or (b) you and/or your Provider provide medical and scientific information establishing that your participation in the qualified clinical trial is appropriate according to the trial protocol.

A qualifying clinical trial means any phase of a clinical trial that is conducted in relation to the prevention, detection, or treatment of certain life-threatening conditions including cancer provided one of the three

following criteria are met:

1. The study or investigation is approved or funded (including funding through in-kind contributions) by one or more of the following:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - Cooperative group or center of any of the above four entities or the Department of Defense or the Department of Veterans Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the Department of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
2. The study or investigation is conducted under an Investigational new drug, device or procedure application by the U.S. Food and Drug Administration (FDA).
3. The study or investigation is a drug trial exempt from having such an Investigational new drug application.

Limitations and Exclusions

The following services are not Covered Health Services under the Policy:

- Cost of the clinical trial itself.
- Routine Patient Care Costs and/or Services do not include the Investigational item(s), device(s) or service(s) themselves.
- In addition, non-Covered services include any item, device, or service:
    - That is provided at no cost by the research sponsors.
    - Used to satisfy data collection, biostatistical documentation, interpretation and analytics, and similar study analysis requirements.
    - Not used to direct *clinical* management of the patient.
    - Obtained Out-of-Network when non-network Benefits do not exist or are applicable under the Plan.
    - That is inconsistent with widely accepted and established standards of care for a particular diagnosis or management of associated symptoms.
- Routine patient care costs associated with a clinical trial for Out-Of-Network Clinical Trials.

COCHLEAR IMPLANT

Coverage includes Covered Health Services for cochlear implants for individuals with severe-to-profound hearing loss who only receive limited Benefit from amplification with hearing aids. Cochlear implants are deemed Medically Necessary when used in accordance with the US Food and Drug Administration label indications.

Limitations and Exclusions
The following services are not Covered Health Services or have limitations under the Policy:

- Outpatient Rehabilitation Services for post-cochlear implant aural therapy are limited to 30 visits per year.
- Batteries, cords and other accessories.

CONTRACEPTIVE MEDICATIONS AND DEVICES

Covered Services
Coverage includes Covered Health Services for drugs or devices approved by the U.S. Food and Drug Administration (FDA) to prevent Pregnancy. Covered Health Services may be subject to CareSource's Prescription Drug formulary. Coverage also includes medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive.

All contraceptive medications and devices defined within the formulary as Preventive will be dispensed at no cost to the member. More information about the Preventive services coverage required under the Affordable Care Act can be found in ***Section 7 under Preventive Care Services***.

DENTAL

Coverage for general dental services is limited to the following:

- Oral examination, X-rays, extractions, and non-surgical elimination of oral infection required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:
  - The direct treatment of acute traumatic Injury, cancer or cleft palate.
  - Transplant preparation.
  - Prior to the initiation of immunosuppressive drugs.

Limitations and Exclusions
The following services are not Covered Health Services or have limitations under the Policy:

- Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia)
  - This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in below and Anesthesia Services and Temporomandibular Joint Disorder Services ***Section 7: Covered Health Services and Limitations***.
- Dental care required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.
- Endodontics, periodontal surgery and restorative treatment are excluded except as related to trauma.
- Preventive Care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
  - Extraction, restoration and replacement of teeth.
  - Medical or surgical treatments of dental conditions.
  - Services to improve dental clinical outcomes.
- Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only and Oral Surgery below and Anesthesia Services, and

Temporomandibular Joint Disorder Services in ***Section 7: Covered Health Services and Limitations***.

- Dental braces (orthodontics).
- Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly, for Cosmetic surgery performed only to improve appearance.

Note**:** This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only below and Anesthesia Services and Temporomandibular Joint Disorder Services in ***Section 7: Covered Health Services and Limitations***.

DENTAL SERVICES – ACCIDENT ONLY

Coverage includes Covered Health Services for dental services when all the following are true:

- Treatment is necessary because of accidental damage to the teeth and/or gums, jaws, cheeks, lips, tongue, roof and floor of mouth.
- Dental services are received from a Doctor of Dental Surgery, Oral Surgeon or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Provider or dentist occurred within 72 hours of the accident. (You may request an extension of this time period if you do so within 60 days of the Injury and extenuating circumstances exist due to the severity of the Injury).

Please note that dental damage that occurs as a result of normal Activities of Daily Living is not considered as having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following timeframes:

- Treatment is started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary Diagnostic x-rays.
- Temporary splinting of teeth.
- Endodontic (root canal) treatment.
- Prefabricated post and core.
- Extractions.
- Maxillofacial surgery to correct traumatic fractures.
- Anesthesia.
- Post-traumatic crowns if they are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

DIAGNOSTIC TESTING

Covered Services

Covered Health Services include Diagnostic tests or procedures, such as, X-ray, CT, and laboratory services, generally performed when you have specific symptoms to detect or monitor your condition. Diagnostic Testing does not include Preventive screening services.

DIABETES SUPPLIES AND EQUIPMENT

Covered Benefits include the following when included on the Prescription Drug List: insulin, Prescription drugs prescribed for treatment of diabetes, test strips, lancets, syringes and hypodermic needles for administration of insulin, and certain non-invasive continuous glucose monitors. Durable Medical Equipment which is Covered under this health Plan includes but is not limited to insulin infusion devices and other non-invasive continuous glucose monitors which are used with an insulin infusion device. Nutritional counseling and self-management training with a diagnosis of diabetes is also a Covered Benefit. We may establish reasonable quantity limits for certain supplies, equipment or appliances.

DURABLE MEDICAL EQUIPMENT

Covered Services

Covered Health Services include Durable Medical Equipment prescribed by an In-Network Provider and obtained from an In-Network Durable Medical Equipment Provider. Durable Medical Equipment coverage includes but is not limited to equipment for home use including patient-controlled analgesia (pain) pumps, oxygen regulators, infusion pumps and specialized feeding equipment. It also includes prosthetic devices to replace a missing body part, including artificial limbs and artificial eyes. Durable Medical Equipment such as a wheelchair or hospital bed is also Covered.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs as determined by CareSource. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece CareSource has determined is the most cost-effective Durable Medical Equipment. We reserve the right to decide whether to rent or purchase Durable Medical Equipment. We may establish reasonable quantity limits for certain supplies, equipment or appliances.

Benefits under this section also include speech aid devices and trachea-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and trachea-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the Schedule of Benefits.

CareSource will decide if Covered Durable Medical Equipment will be purchased or rented. We may choose to pay the rental up to the purchase price. Durable Medical Equipment must be purchased or rented from an In-Network Provider. Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage, or gross neglect.
- Benefits are not available to replace lost or stolen items.

Limitations and Exclusions

The following devices, appliances and prosthetics services are not Covered Health Services or have limitations under the Policy:

- Speech aid devices and trachea-esophageal voice devices for which Benefits are provided as described above in this section.
- Post-Mastectomy Bras – quantity limits apply.
- Cranial remodeling helmets
- Disposable supplies necessary for the effective use of Durable Medical Equipment for which

Benefits are provided as described.
- Diabetic supplies for which Benefits are provided as described.
- Patient Lift Systems
- Phototherapy beds – except in certain situations
- Ostomy supplies except for which Benefits are provided as described under Ostomy Supplies **Section 7: *Covered Health Services and Limitations***.
- Tubing and masks except when used with Durable Medical Equipment as described.
- Insulin infusion devices except for which Benefits are provided, or any equipment required to be Covered as a Preventive Care service in **Section 7: *Covered Health Services and Limitations***.
- Equipment or supplies for which the only advantage of a suitable alternative is convenience or personal preference.
- Devices used specifically as safety items or to affect performance in sports-related activities.
    - Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Off-the-shelf/over-the-counter or member purchased items not prescribed or ordered by a qualified healthcare Provider.
- Equipment or supplies to facilitate participation in physical activity or sports.
- The following items, even if prescribed by a Provider:
    - Blood pressure cuff/monitor.
    - Enuresis alarm.
    - Non-wearable Automatic External Defibrillator (AED).
    - Trusses.
    - Ultrasonic nebulizers.
    - Continuous passive motion (CPM) machine.
- Devices and computers to assist in communication and speech, except as described above for speech aid devices and trachea-esophageal voice devices.
- Oral appliances for snoring.
- Repair or replacement of equipment due to misuse, malicious damage or gross neglect.
- Replacement of lost or stolen items.
- Routine maintenance of equipment, regardless of whether it was rented or purchased.
- Any supplies or equipment which can be purchased over-the-counter without a Prescription, other than those listed in "Diabetes Supplies and Equipment" section. This includes, but is not limited to, items such as gauze, bandages and tape.
- Equipment or supplies for comfort, personal hygiene, convenience, or which are otherwise useful in the absence of Illness, Injury or disability.
- Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

EMERGENCY HEALTH SERVICES – OUTPATIENT

Covered Services

Coverage includes Covered Health Services that are required to stabilize or initiate treatment in an Emergency. Medically Necessary services that We determine meet the definition of Emergency Health Services will be Covered whether rendered by In-Network or Out-of-Network Providers. Emergency Health Services rendered by an Out-of-Network Provider will be Covered at the network rate of pay subject to the Qualifying Payment Amount. For Emergency Health Services, CareSource will not pay charges in excess of the Qualifying Payment Amount. The member is responsible for any cost-sharing amounts for the Plan and cannot be balance-billed for charges in excess of the Qualifying Payment

Amount.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment, including placement in an Observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Confinement). Observation Stays are Covered for up to 48 hours, after 48 hours Prior Authorization would be required.

Examples of Emergencies can include but are not limited to chest pain or difficulty breathing, choking, weakness or numbness on one side, slurred speech, fainting or a change in Mental status, serious burns, head or eye Injuries, concussions or confusion, broken or dislocated bones, fever with a rash, seizures, severe cuts that require stitches, facial lacerations, severe cold or flu or vaginal bleeding with Pregnancy.

GENETIC TESTING AND COUNSELING

Covered Services

Covered Health Services include Genetic Testing and Genetic counseling. Genetic Testing and Genetic counseling will be a Covered Benefit when Medically Necessary for Diagnostic purposes. Genetic Testing and/or Genetic counseling may be provided for other diseases or health conditions.

HABILITATIVE SERVICES

Coverage includes Covered Health Services for Habilitative Services defined as those health care services that help a person keep, learn or improve skills and functioning for daily living (for example, therapy for a child who isn't walking or talking at the expected age).

Treatment must be evidence-based physical, occupational, or speech therapy provided by an appropriately licensed therapist under the direction of a Provider in accordance with a written treatment plan established or certified by the treating Provider. Physical, occupational, or speech therapy is limited to twenty (20) physical therapy (PT) visits, twenty (20) occupational therapy (OT)visits, and twenty (20) speech therapy (ST) visits per year. These services are not to be combined with Rehabilitative Services.

Limitations and Exclusions

The following services (but are not limited to) are not Covered Health Services or have limitations under the Policy:

- Respite care
- Day care
- Recreational care
- Residential treatment (except described in this section under Mental Health and Substance Use Disorder Services)
- Social services
- Custodial care
- Education services of any kind

HEARING SERVICES AND HEARING AIDS

Covered Services

Coverage includes Covered Health Services for Diagnostic testing to establish or confirm hearing loss and determine the cause, treatment of hearing impairment/loss caused by Injury or Illness, surgery to repair anatomic or functional disorders associated with hearing loss, and hearing aids for Covered Persons who

are certified as deaf or hearing impaired by either a Provider or audiologist licensed under Wisconsin law, including services, diagnoses, surgery, and therapy provided in connection with the hearing aid.

Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this Certificate, only for Covered Persons who have the following:

- Craniofacial anomalies which preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that a wearable hearing aid would not adequately remedy it.

Limitations and Exclusions

The following services are not Covered Health Services or have limitations under the Policy:

- Hearing aids are limited to one (1) hearing aid per ear every thirty-six (36) months.
- Bone anchored hearing aids except when any of the following apply:
    - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals prevent the use of wearable hearing aids.
    - For Covered Persons with hearing loss of sufficient severity that such hearing loss would not be adequately remedied by a wearable hearing aid.
    - Absent ear canals preclude the use of a wearable hearing aid.
    - Repair and/or replacement for a bone anchored hearing aid for Covered Persons who meet Medical Necessity requirements.
- Batteries, cords, and other accessories.
- More than one bone anchored hearing aid per Covered Person per lifetime.
- Off-the-shelf/over-the-counter or member purchased hearing aids not prescribed or ordered by a qualified healthcare Provider.
- Hearing aids, even if prescribed by a provider, in the case of absent ear canals due to Congenital Anomalies or trauma which prevent the use of wearable hearing aids.
- Repairs and/or replacement, other than related to malfunctions, for a bone anchored hearing aid.

HOME HEALTH CARE

Covered Services

Coverage includes Medically Necessary services received from a Home Health Agency that meet all the following criteria:

- The Provider orders the service.
- The service is provided in your home by an In-Network state-licensed or Medicare-certified Home Health Agency.
- The services are provided on a part-time or Intermittent Care schedule.
- Confinement in a Hospital or Skilled Nursing Facility would otherwise be needed if Home Health services were not provided.
- Necessary care and treatment are unavailable from immediate family or other people in the same household without causing undue hardship.
- Skilled care is required.

Skilled care is Skilled Nursing, skilled teaching and/or Skilled Rehabilitation Services such as Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) when all the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel (e.g., RN, PT, OT, ST, Dietician, or Social Worker) to obtain a specified medical outcome and provide for the patient's safety. It requires clinical training in order to be delivered safely and effectively.

- It is not delivered to assist with daily living activities, such as dressing, feeding, bathing or transferring from a bed to a chair. It is not Custodial Care or for maintenance.

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

Limitations and Exclusions
The following services are not Covered Health Services or have limitations under the Policy:

- Services by nursing assistants and/or personal care workers.
- Home health care Benefits are limited to 60 visits per calendar year. Up to four hours of consecutive skilled care services equals one home health visit.
- Home health aide visits.

HOSPICE AND PALLIATIVE CARE

Covered Services

Hospice Care
Coverage includes hospice care for Covered Persons as recommended by a Provider. Hospice care is a program that provides comfort care and medical support services for the terminally ill for pain relief and symptom management. Care may be provided in the home or at a hospice facility. CareSource may have programs that provide an enhanced or reduced Benefit based on the care setting you choose. Please contact Us at 877-514-2442 for more information.

To be eligible for hospice Benefits, the patient must have a life expectancy of one year or less, as confirmed by the attending Provider. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person. Benefits are available when hospice care is received from a licensed hospice agency.

Medically Necessary hospice care services and supplies listed below are Covered if part of an approved treatment plan and when rendered by a hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Please refer to the Schedule of Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the exclusions and limitations section for services that are not Covered. Covered Health Services include:

- Care rendered by an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Facility Care when required in periods of crisis or as respite care.
- Skilled Nursing Services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Dietary support.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition, including oxygen and related respiratory therapy supplies.

To receive hospice Benefits, your Provider and the hospice medical director must certify that you are terminally ill and generally have less than one year to live, and your Provider must consent to your care by the hospice and must be consulted in the development of your treatment plan. The hospice must maintain a written treatment plan on file. Additional Covered Health Services to those listed above (such

as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal Illness are available while in hospice. Benefits for these additional Covered Health Services, which are described in other parts of the Policy, are provided as therein.

Palliative Care
Palliative Care is a supportive care service for patients with chronic medical conditions for symptom management. Care may be provided in a home setting, a clinic or a Hospital. This approach improves the quality of life of patients and their families' facing challenges through the prevention and relief of suffering by means of early identification, assessment, and treatment of pain and other related health issues. Palliative Care is not meant to cure a life-limiting Illness, but rather is focused on improved comfort and quality of life. To receive the Benefits of palliative care, your Provider must order palliative care with a hospice certified Provider who is in network. The supportive care team is an interdisciplinary team who will work with your Provider to help you be successful managing your chronic condition, perform advance care planning, assist in managing medications and help you to remain successful in your home.

INPATIENT CONFINEMENT

Covered Services
Coverage includes Covered Health Services and supplies provided during Inpatient Confinement in a Hospital. Benefits are available for:

- Room and board in a Semi-Private Room (a room with two or more beds) or in a private room where a Semi-Private Room is unavailable.
- Ancillary services and supplies – services received during the Inpatient Confinement including operating, delivery and treatment rooms, equipment, Prescription Drugs, Diagnostic and therapy services. Provider services for radiologists, anesthesiologists, pathologists and Emergency room Providers. (Benefits for other Provider services are described under Provider Fees for Surgical and Medical Services.)

INPATIENT REHABILITATION

Covered Services
Covered Health Services include Inpatient Rehabilitation Services for an individual who requires specialized care to restore functional ability following an Illness or Injury you must be able to participate in Rehabilitative Services a minimum of three hours per day for at least five days per week and your condition requires you to see a Provider at least three times per week. Room and board, physician, Skilled Nursing and Skilled Rehabilitation Services and Prescription and non-Prescription medications are a Covered Benefit. The individual must be capable of actively participating in a Rehabilitative program and recovery is less likely to occur in a sub-acute care setting.

Inpatient Skilled Rehabilitation Facility care that is primarily considered Custodial or Long-Term Care is not Covered.

Limitations and Exclusions
The following service is not a Covered Health Service or has limitations under the Policy:

- Coverage is limited to 60 days per calendar year.

KIDNEY DISEASE TREATMENT

Covered Services

Coverage includes Inpatient and outpatient kidney disease treatment including dialysis, transplantation, and donor-related services. These include:

- Inpatient and outpatient kidney disease treatment.
- Services and supplies directly related to kidney disease, including, but not limited to dialysis, transplantation, donor-related charges, and related health care Provider charges.

Donor-related charges are only payable if the kidney recipient is a Covered Person. The Covered-donor-related-charges (including compatibility testing charges) are those charges related to the person donating the kidney.

CareSource is not required to duplicate coverage available to a Covered Person under Medicare or any other insurance coverage a Covered Person may have. An individual can become eligible for Medicare due to end stage renal disease or dialysis status. If or when that happens, We coordinate Benefits with Medicare at the time you become enrolled in Medicare.

Benefits are not available for the following:

- Any transplants and related expenses not outlined as Covered in this subsection.
- Any Experimental or Investigational transplant.
- Transplants involving non-human or artificial organs.
- If a Covered Person is enrolled in Medicare, kidney disease treatment services may not be Covered by CareSource unless coverage is required by state and/or federal law.

LABORATORY SERVICES

Covered Services

Coverage includes Medically Necessary services for Sickness and Injury-related Diagnostic purposes, received on an outpatient basis at a Hospital, Clinic or Alternate Facility. These include lab tests when Medically Necessary and appropriate for the diagnosis of a Sickness, or Injury, to monitor the effects of a drug (for example, therapeutic drug monitoring) or when such testing is Medically Necessary to monitor the state of certain acute or chronic Illnesses from time-to-time, and Infertility Diagnostic tests.

Laboratory tests for Preventive Care are described under Preventive Care services.

MATERNITY AND NEWBORN BENEFITS

Covered Services

Coverage for maternity includes all Pregnancy-related medical services for prenatal care, postnatal care, delivery, and any related complications. A Covered Person's Pregnancy includes a Covered Person serving as a surrogate host/gestational carrier.

Covered Health Services for Newborns include the following:

- Nursery room, board and care, after birth while the newborn is still in the Hospital including care and treatment of a newborn immediately after birth for concerns which may include but are not limited to pre-term or premature birth, low birth weight, respiratory distress syndrome (RDS), failure to thrive or neonatal jaundice. Coverage includes an Inpatient stay at the time of delivery of at least: 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

- Routine and Preventive exam or services when received by the newborn before release from the Hospital.
- Circumcision when rendered prior to discharge from the Hospital.
- Plastic or reconstructive surgery, in order to reconstruct or restore function to a dysfunctional body part present at birth.

If you are Pregnant and your Provider terminates participation in the CareSource Provider network for reasons other than cause, you may have Continuity of Care rights, ***See Section 5 under Continuity of Care***.

Limitations and Exclusions
The following services are not Covered Health Services or have limitations under the Policy:

- Elective abortions, except when performed to save the life/health of the mother and in instances of rape or incest.
- Home or intentional out of Hospital deliveries.
- Amniocentesis or Chorionic Villi Sampling (CVS) performed exclusively for sex determination.
- Birthing classes.
- Donor Milk
- Treatment, services, or supplies for a third party or nonmember traditional surrogate or gestational carrier.
- Midwife labor and delivery services received outside the Hospital.
- Amniocentesis or ultrasound performed for non-Medically Necessary indications.

Breast pumps are Covered if ordered by a licensed professional after the birth of a child. Coverage is limited to one standard manual, simple breast pump or one basic single electric pump.

NUTRITIONAL EDUCATION AND COUNSELING

Covered Services
Coverage includes health services for nutritional education services that are provided by licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease or condition in which patient self-management is a necessary component of treatment.
- There exists a knowledge deficit regarding the disease or condition which requires the intervention of a trained nutritional health professional.

Limitations and Exclusions
The following services are not Covered Health Services or have limitations under the Policy except as described as Covered Health Services under Diabetes Services:

- Individual and group nutritional counseling except when counseling is required to be Covered as a Preventive Care service. Infant formula and donor breast milk.
- Nutritional or Cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).
- 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.
- Nutritional counseling associated with weight loss programs.

ORAL SURGERY

Coverage includes Covered Health Services for oral surgery limited to the following:

- Excision of tumors, cysts and abscesses of the jaws, cheeks, tongue, roof and floor of the mouth.
- Repair of traumatic maxillofacial Injuries or fractures

Limitations and Exclusions

The following services are not Covered Health Services under the Policy:

- Oral surgeries for tooth extraction (i.e., wisdom teeth extraction).
- Excision or treatment related to abscesses of the tooth.

OSTOMY SUPPLIES

Covered Services

Coverage includes Covered Health Services for ostomy supplies limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Note: We may establish reasonable quantity limits for certain supplies, equipment or appliances.

Limitations or Exclusions:

The following services are not Covered Health Services under the Policy:

- Deodorants
- Filters
- Lubricants
- Tape
- Appliance cleaners
- Adhesive
- Adhesive remover
- Any other items not listed above

PARENTERAL AND ENTERAL NUTRITION IN THE HOME

Covered Services

Coverage includes Covered Health Services for oral enteral and parenteral nutrition when all the criteria are met:

- The product must be medical food for oral or tube feeding;
- The product must be the primary source of nutrition, i.e., more than half the nutritional intake for the individual;
- The product must be labeled and used for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements to avert the development of a serious physical or Mental disability or to promote normal development and function; and
- The product must be used under the supervision of a Provider or ordered by a registered dietician upon referral by a healthcare Provider authorized to prescribe dietary treatments.

When and if the member is medically appropriate, introduction to oral nutrition is preferred and will be

worked toward at medically appropriate intervals as soon as medically able at which time enteral or paternal feeding should be weaned. We may establish reasonable quantity limits for certain supplies, equipment or appliances.

PHARMACEUTICAL PRODUCTS – OUTPATIENT

Covered Services

Coverage includes Covered Health Services for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Provider's office, or in a Covered Person's home. We may have programs in which you may receive an enhanced or reduced Benefit based on the care setting you choose. Please contact Us for more information.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by Us), must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional. We may establish reasonable quantity limits for certain supplies, equipment or medications. Benefits under this section do not include medications that are typically available by Prescription order or refill at a pharmacy using your Prescription Drug card.

PODIATRY SERVICES

Covered Services

Coverage includes Covered Health Services for podiatry services limited to:

- Treatment of foot disorders, including medical or surgical treatment related to disease, Injury, or defects of the feet.
- Medically Necessary Routine foot care for Covered Persons with certain chronic conditions.

Limitations and Exclusions

The following services are not Covered Health Services or have limitations under the Policy:

- Routine foot care is not Covered. Routine food care services commonly involve:
    - The cutting, paring, shaving or removal of thickened (hypertrophied) skin, subcutaneous tissue, corns, and calluses (whether painful or not).
    - The simple cutting, paring, or shaving of hypertrophied skin caused by plantar warts (in the absence of definitive therapy such as cryoablation – see below).
    - The trimming, cutting, clipping, debridement of nails.
    - The surgical treatment or debridement of mycotic nails (onychomycosis, toenail fungus).
    - Other hygienic and Preventive foot care including cleaning/washing and soaking the feet, the use of skin creams or ointments to maintain skin tone or hydration, and similar services performed in the absence of systemic Illness, Injury or specific symptoms involving the feet and nails.
- Treatment of pes planus (flat feet).
- Procedures designated as Cosmetic or solely performed to improve physical appearance.
- Reimbursement for custom shoes, or for the fitting of other footwear, inserts, lifts, arch supports, or similar orthotics.

Exceptions to Non-Covered, Routine Foot Care Services:

- The above exclusions do not apply to Covered Persons with certain conditions including, but not limited to:
    - Diabetes

  - Peripheral vascular disease
  - Arteriosclerosis
  - Chronic thrombophlebitis
  - Peripheral neuropathies.
- Routine foot care is a Covered Benefit for members with certain systemic Illnesses because they can result in vascular or neurologic compromise including ischemia (diminished or absent blood flow), ulcers (open sores), edema (swelling), wounds, infections, or diminution of protective sensation in the lower extremities or feet. In such circumstances where neurovascular integrity may be compromised, performing Routine foot care by a clinician may be preferable in order to prevent self-Injury or future complication(s).
- Treatment of Plantar Warts (Verrucae):
  - The paring of hypertrophic skin or tissue secondary to plantar warts is a Covered Benefit when used in conjunction with a definitive treatment modality such as cryoablation.

PREVENTIVE CARE SERVICES

Covered Services

There are three types of Preventive Care an individual may receive, but only two are considered Covered Health Services under your Plan:

- **Covered With No Cost Share:** Your Benefits include certain Preventive Care Covered at 100% (no cost to Covered Persons) as long as the care is received In-Network.
- **Covered With Cost Share:** Your Benefits include certain Preventive Care received In-Network that is not Covered at 100% and may be subject to Deductibles, Copays and/or Coinsurance.
- **Not Covered:** Benefits do not include Preventive Care that is not Medically Necessary or is otherwise listed as an exclusion.

Two examples of a Preventive Care that would be paid at no cost to a member are 1) a colonoscopy for someone that has no history of polyps, or any other medical concern related to the colon and is getting the colonoscopy simply because it is recommended for individuals who have reached the age of 45 and 2) an annual wellness check-up with an In-Network Primary Care Provider.

However, please be aware that any tests that are done as part of an annual wellness visit are billed separately from the office visit and may be subject to applicable Deductibles, Copays and/or Coinsurance. An example of this is a comprehensive metabolic panel (CMP), which is sometimes done as part of a full blood panel, that would be subject to Deductibles, Copays and/or Coinsurance.

Other examples of tests that are Covered, but are subject to Deductibles, Copays and/or Coinsurance:

- Your first screening colonoscopy after you turn 45 is paid at 100%, but polyps are found. Instead of being on a 10-year screening schedule, you are put on a five-year screening schedule. Your next colonoscopy five years later will not be paid at 100%.
- You have a pap smear test that is abnormal, so you are required to repeat it after six months. The next pap smear test at six months will not be Covered at 100%. Future pap smears will not be Covered at 100% until you go three years without an abnormal test.
- Your doctor orders full blood work at your annual Preventive exam. Only certain blood tests (those mandated by PPACA) will be paid at 100% while others would be subject to Deductibles, Copays and/or Coinsurance.

Preventive Care Services That May Be Covered At 100%

For Preventive services Covered with no Cost Share described above that may be Covered at 100%, it is important to know that limitations apply that may impact whether the service will be Covered in full. The procedure, test or treatment must be considered a "screening test", meaning a test that is performed to determine if you have a condition, even though you may have no symptoms. It must also be appropriate for your age as described and provided on an outpatient basis at an In-Network Provider's office or an Alternate Facility. It is also important to understand that the services listed below are still subject to all the provisions of the Policy, including Medical Necessity and any limitations or exclusions.

Preventive Care services have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease and have been proven to have a beneficial effect on health outcomes. They include the following:

- Evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Immunizations for children, adolescents, and adults that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
- For infants, children and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- For women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

The Plan provides Benefits for Preventive Care services without applying a Deductible, Coinsurance or Copayment when these services are provided by an In-Network Provider in a primary care setting. CareSource covers these services consistent with the recommendations and guidelines of the United States Preventive Service Task Force (USPSTF) or other regulatory organizations based on age, health status, gender guidelines, and medical evidence. Consult your doctor for your specific Preventive health recommendations.

Preventive Care services may not be performed for the primary reason of diagnosing or treating a Sickness or Injury. Additional services may be added when required by law.

PROSTHETIC DEVICES

Covered Services

Coverage includes Covered Health Services for external prosthetic devices that replace a limb or a body part, but is limited to:

- Replacement of natural or artificial limbs and eyes, ears and nose no longer functional due to physiological change or malfunction beyond repair.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits are available for repairs and replacement, except that there are no Benefits for replacement or repairs due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices. We may establish reasonable quantity limits for certain supplies, equipment or appliances.

Benefits under this section are provided only for external prosthetic devices and may not include some devices that are fully implanted into the body that are not considered Medically Necessary. The prosthetic device must be ordered or provided by, or under the direction of, a Provider.

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

PROVIDER'S OFFICE SERVICES – SICKNESS AND INJURY

Covered Services

Coverage includes Covered Health Services provided in a Provider's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Provider's office is free-standing, located in a clinic or located in a Hospital. Benefits include medical education services that are provided in a Provider's office by appropriately licensed or registered healthcare professionals when both of the following are true:

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

Benefits under this section include allergy injections, labs, radiology/X-rays or other Diagnostic services performed in the Provider's office. Benefits under this section do not include CT scans, PET scans, MRIs, MRAs, nuclear medicine and major Diagnostic services.

Covered Health Services for Preventive Care provided in a Provider's office is described under Preventive Care services.

REHABILITATION SERVICES – OUTPATIENT THERAPY

Covered Services

Coverage includes Covered Health Services for short-term outpatient Rehabilitation Services, limited to:

- **Physical therapy** is limited to 20 visits per year. This limit does not include services as described under Habilitative Services in ***Section 7: Covered Health Services and Limitations***.
- **Occupational therapy** is limited to 20 visits per year. This limit does not include services as described under Autism Spectrum Disorder Services***:*** or Habilitative Services in ***Section 7: Covered Health Services and Limitations***.
- **Speech therapy** is limited to 20 visits per year. This limit does not include services as described under Autism Spectrum Disorder Services or Habilitative Services in ***Section 7: Covered Health Services and Limitations***.
- **Cardiac Rehabilitation therapy** is limited to 36 visits per year.
- **Post-cochlear implant aural therapy** is limited to 30 visits per year.
- **Cognitive Rehabilitation therapy** is limited to 20 visits per year.
- **Pulmonary Rehabilitation therapy** is limited to 36 visits per year and must be performed by a Provider or by a licensed therapy Provider. Benefits under this section include services provided in a Provider's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Rehabilitation Services or if Rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed manipulative treatment or if treatment goals have previously been met. Benefits under this section are not available for

maintenance/Preventive manipulative treatment.

Please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing. For speech therapy with relation to Autism Spectrum Disorders, please refer to the services described under Autism Spectrum Disorder Services in ***Section 7: Covered Health Services and Limitations***.

CareSource will pay Benefits for cognitive Rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebrovascular accident (stroke).

Limitations and Exclusions
The following services are not Covered Health Services or have limitations under the Policy:

- Rehabilitation services and manipulative treatments to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including Routine, Long-Term or maintenance/Preventive treatment.
- Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder.
- Outpatient cognitive Rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebrovascular accident (stroke).

REPRODUCTIVE HEALTHCARE SERVICES

Covered Services
Covered Health Services include the following services:

- Tubal ligation and Oviduct Occlusion.
- Removal of both fallopian tubes which meets Medical Necessity requirements.
- Vasectomy performed in Provider's office. If scheduled at another facility (i.e., at an ambulatory surgery center – ASC or in a Hospital outpatient or Inpatient setting).

Certain Tubal Ligation and Oviduct Occlusion procedures may be considered Preventive. **See Section 7 under Preventive Care Services** for more information about the Preventive services coverage.

Services for or connected to the reversal of a tubal ligation or vasectomy are not Covered. Also not Covered are Diagnostic tests connected to the treatment of infertility, including but not limited to Diagnostic studies to determine when ovulation is occurring or will occur, abdominal ultrasounds to determine follicle growth; and Diagnostic services that would not be performed outside of infertility treatment. Other than surgical repair, any physician, Hospital or other service connected to infertility treatment, such as laparoscopic or transvaginal retrieval of an ovum is not Covered. In addition, services for, or connected to, any artificial, mechanical, or other alternative to natural conception. This includes but is not limited to In vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), intracytoplasmic sperm injection (ICSI), embryo transplantation, artificial insemination, sperm and embryo storage and other similar methods or procedures. Medication prescribed to treat infertility, including but not limited to drugs for hyperstimulation of the ovaries (such as Clomiphene Citrate) and drugs for treating low sperm count or motility.

Limitations and Exclusions
The following services are not Covered Health Services or have limitations under the Policy:

- Elective abortions, except when performed to save the life/health of the mother and in instances of rape or incest.
- Home or intentional out of Hospital deliveries.

- Amniocentesis or Chorionic Villi Sampling (CVS) performed exclusively for sex determination.
- Birthing classes.
- Treatment, services, or supplies for a third party or nonmember traditional surrogate or gestational carrier.
- Services provided by a third-party doula or similar non-CareSource-credentialed clinical Provider.
- If a diagnosis of infertility has already been established, no additional fertility testing is Covered.
- Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
- Surrogate parenting, including maternity services and any other treatment, services or supplies for a Covered Person's surrogate, sperm or other insemination, donor eggs, donor sperm and host uterus. This exclusion does not apply only to those maternity services otherwise payable under the Policy for a Covered Person's Pregnancy while the Covered Person is serving as a surrogate host/gestational carrier.
- Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
- The reversal of voluntary sterilization and related procedures.
- In-vitro fertilization regardless of the reason for treatment.
- Equipment, devices, services or other items to treat impotence and erectile dysfunction.
  Note**:** Diagnosis and treatment of Medically Necessary underlying causes of infertility may be Covered. However, the Plan may exclude assisted reproductive technologies including, but not limited to:
  - Artificial insemination (AI) and intrauterine insemination (IUI)
  - In vitro fertilization (IVF)
  - Natural cycle IVF

SKILLED NURSING FACILITY

Covered Services

Covered Health Services include services and supplies provided in a Skilled Nursing Facility (SNF). Benefits must meet Medical Necessity criteria and are available for:

- Up to and including 30 days per stay.
- Room and board in a Semi-Private Room (a room with two or more beds) or in a private room where a Semi-Private Room is not available.
- Ancillary services and supplies — services received during the Inpatient Confinement, including Prescription Drugs, Diagnostic and therapy services.

Hospital swing bed Inpatient Confinement is considered the same as a stay in a Skilled Nursing Facility. If the Member is transferred to another facility for continued treatment of the same or related condition, it is still considered one stay. For SNF, the stay begins on the day of admission into a Skilled Nursing Facility. The SNF Benefit renews when you haven't received Inpatient Hospital care or skilled care in a Skilled Nursing Facility for the same or a similar diagnosis for sixty consecutive days (60 days in a row). If you go into a Hospital or a Skilled Nursing Facility after one SNF Benefit period has ended, a new Benefit period begins. There is no limit to the number of SNF stay Benefit periods. However, additional days are not available until skilled care has not been required for at least 60 consecutive days.

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

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

Skilled care is Skilled Nursing, skilled teaching and Skilled Rehabilitation Services when all the following are true:

- Services must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- Services must be ordered by a Provider.
- Services are not delivered exclusively for the purpose of assisting with Activities of Daily Living, including dressing, feeding, bathing or transferring from a bed to a chair.

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

Benefits can be denied or discontinued for Covered Persons who are not progressing in goal-directed Rehabilitation Services or if discharge Rehabilitation goals have previously been met.

Skilled Nursing Facility care, which is primarily considered Custodial or Long-Term Care, even if provided by a registered nurse, a licensed practical nurse, or another trained medical professional, is not Covered. This can include periodically turning and repositioning a non-ambulatory patient, prophylactic or palliative skin care, such as bathing and applying creams or lotions, administering Routine medications, eye drops and ointments. This can also include wound care for non-infected post-operative wounds and/or non-infected wounds caused by a chronic medical condition. In addition, general administration of oxygen and other inhalation therapy after the initial phase of treatment adjustments and caregiver training are completed. Also included in the Covered services are conditions which can reasonably and safely be performed after having learned them. Examples of these include, but are not limited to Routine insulin injections, self-urinary catheterizations, and Long-Term feeding by gastrostomy or jejunostomy tube. General maintenance of ostomies or catheters care are also not Covered Benefits.

SURGERY – OUTPATIENT

Covered Services

Coverage includes Covered Health Services for surgery and related services received on an outpatient basis at a Hospital Ambulatory Surgical Center or in a Provider's office within the parameters of this section. Please check ***Section 9: Exclusions*** to understand the requirements and limits on coverage for specific surgical Benefits.

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

Benefits under this section include:

- The facility charges and the charges for supplies and equipment for Medically Necessary services.
- Provider services for radiologists, anesthesiologists, and pathologists. Benefits for Provider services are described under Provider Fees for Surgical and Medical Services provision.

Breast Reconstruction and Treatment Special Coverage Rules:

- The following surgical services have additional, special coverage rules or requirements in addition to the ones stated above:
  - Reconstructive surgery following mastectomy, including all stages of reconstruction of the breast for which a mastectomy was performed.
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance.
  - Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

Limitations and Exclusions

The following services are not Covered Health Services or have limitations under the Policy:

- Surgery related services that CareSource considers unsafe, ineffective or unproven. Surgery-related services that are primarily performed to improve appearance (e.g., Cosmetic Surgery); and will not likely restore a bodily function or result in meaningful improvement to the functionality of a malformed body part.
- Services for or connected to surgical weight management programs and surgical treatment for obesity are not Covered, including but not limited to:
    - Roux-en-Y gastric bypass.
    - Sleeve gastrectomy.
    - Biliopancreatic diversion with duodenal switch.
    - Laparoscopic adjustable gastric banding.
    - Endoscopically placed gastric balloon.
    - Other, similar types of bariatric surgery.
- Bariatric surgery, including gastric restrictive, bypass, and other similar surgeries, and treatment of any related complications. This exclusion applies regardless of diagnosis or the reason the surgery was performed.
- Services that are generally included in the global surgical fee.
- Surgery-related services that are not Covered under this Plan.
- Costs related to early admission before surgery, if pre-surgery services can be performed in an outpatient setting.
- Animal to human transplants.
- Artificial or mechanical devices implanted or designed to replace human organs.

TELEHEALTH

Covered Services

A Covered Health Service, as defined and explained throughout this document, may be Covered when rendered as a Telehealth Service. Telehealth Services may also be referred to as E-Visits, Video Visits, and/or Virtual Health and may be performed by a primary care Provider, specialist or other qualified healthcare Provider who is part of the CareSource Provider network. Telehealth Services are not intended to replace or be utilized in lieu of Emergency Services. An excluded or limited service would also be excluded or limited when rendered as a Telehealth Service.

Telehealth visits with an In-Network Provider, to address acute medical symptoms can be used to address both physical and behavioral health symptoms. In some instances, the Virtual Visit Health Care Provider may recommend that you seek services in a clinic or other health care setting to receive the most appropriate treatment.

Telehealth Visits with Out-of-Network Providers including any other remote electronic communication or interaction between a Provider and a member, or a member's Authorized Representative, or other individual, that does not meet the definition of Telehealth Visit are not Covered. This includes, but is not limited to:

- Telephone-only communication.
- Text message.
- Email.
- Exchanging messages through an electronic health record website or app, or through a patient

portal.
- Remote patient health monitoring.

This also includes communication between Providers, including but not limited to email, communication through electronic health records, and other asynchronous transmission of patient health information, telephone calls or text messages.

We may deny coverage for certain Telehealth or virtual visits that cannot reasonably be completed in an online environment or with online technology (e.g. comprehensive adult, child or newborn physical examinations).

TEMPOROMANDIBULAR DISORDER (TMD) SERVICES

Covered Services

Coverage includes Covered Health Services for Diagnostic procedures and surgical or non-surgical treatment (including prescribed intraoral splint therapy devices) for the correction of temporomandibular disorders (TMD) and associated muscles, if all the following apply:

- The condition is caused by Congenital, developmental or acquired deformity, disease or Injury.
- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.
- The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

Surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections.

Limitations and Exclusions

The following services are not Covered Health Services or have limitations under the Policy:

- Temporomandibular Disorder (TMD) diagnosis services that general medical consensus considers unproven or unconventional. Such services include, but are not limited to:
    - Electromyography (EMG) or muscle testing.
    - Electronic jaw-tracking systems.
    - Thermography and kinesiography.
    - Ultrasonography.
    - Radiography or regular dental X-rays.
- Orthodontic braces or orthognathic surgery to change the bite.
- Occlusal adjustment or modification of a dental surface to change the bite.
- Restorative therapy or prosthodontic treatment, such as the use of crowns and bridges to balance the bite.
- Ultrasonic treatment, electrogalvanic stimulation, iontophoresis, and biofeedback.
- Transcutaneous electrical nerve stimulation (TENS).
- Nutritional counseling and home therapy programs.
- Services which are not expected to lead to a predictable improvement in health status.
- Services that continue after you reach the expected state of improvement, resolution, or stabilization of your health condition.

- Cosmetic or elective orthodontic care, periodontic care or Routine general dental care.

THERAPEUTIC TREATMENTS – OUTPATIENT

Covered Services

Coverage includes Covered Health Services for therapeutic treatments, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy, and radiation oncology.

Covered Health Services include services by appropriately licensed or registered healthcare professionals when both of the following are true:

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

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

TRANSFUSIONS/INFUSIONS

Covered Services

Coverage includes Covered Health Services for transfusions/infusions and must be for the treatment of a Covered condition:

- Blood and blood product transfusions.
- Infusions requiring medical supervision provided in a Provider's office or home setting.

For transfusion/infusion services to be Covered, they must be provided in the most cost-effective care setting. Please contact Us for more information.

TRANSPLANT SERVICES

Covered Services

Coverage includes Covered Health Services for certain organ and tissue transplants when ordered by a Provider.

Donor costs that are directly related to organ removal are Covered Health Services only if the transplant recipient is Covered under this health Plan. Benefits are payable through the organ recipient's coverage under the Policy. Covered services for the living donor include evaluation, hospitalization, surgical costs, and postoperative care. Procurement, transportation, and preservation of the organ from a deceased donor.

Transplant services must be received at a Designated Facility using Designated Providers or Centers of Excellence (COE) for transplant services. We have specific guidelines regarding Benefits for transplant services. Contact Us at 877-514-2442 for information about these guidelines.

Limitations and Exclusions

The following services are not Covered Health Services or have limitations under the Policy:

- Services and supplies in connection with transplants unless Prior Authorized by CareSource.
- Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable

for a transplant through the organ recipient's Benefits under the Policy.)

- Any Experimental or Investigational transplant, or any other transplant-like technology not listed in this Certificate.
- Any resulting complications from the above and any services and supplies related to such Experimental or Investigational transplantation or complications thereof, including, but not limited to, high dose chemotherapy, radiation therapy, or immunosuppressive drugs.
- Health services for transplants involving artificial, or animal organs.
- Donor costs outside of services related to organ removal (i.e. hotel or transportation).

URGENT CARE CENTER SERVICES

Covered Services

Benefits include Medically Necessary Covered Health Services received at an Urgent Care Center. If you are within the Service Area, you must visit an In-Network Urgent Care Center for Benefits to apply. Outside of the Service Area, you may visit an Out-Of-Network Urgent Care Center or an Out-of-Network Provider for Urgent Care services, but We will pay the Maximum Allowed Amount toward the services, which may be less than the Facility's or Provider's billed charges. Examples of situations for which Urgent Care might be appropriate include, but are not limited to, sprains and strains, cough, cold, and sore throat, mild fever, earaches and infections, non-severe bleeding and minor cuts or burns. Also, see Balance Billing explanation in ***Section 2: Terms and Definitions*** **and** ***Section 5: How to Obtain Covered Health Services.***

URINARY CATHETERS (INTERMITTENT AND INDWELLING)

Covered Services

Coverage includes Covered Health Service for Intermittent and indwelling urinary catheters provided in an appropriate setting when Medically Necessary. A Covered Person must have permanent urinary incontinence or permanent urinary retention. We may establish reasonable quantity limits for certain supplies, equipment or appliances. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected in that person within three months.

VISION EXAMINATIONS

Covered Services

Coverage includes Covered Health Services for a Covered Person without eye disease or diagnosis beyond refraction to detect vision impairment, received from a health care Provider in the Provider's office. Benefits include:

- One annual eye exam performed by an optometrist or ophthalmologist for children through the end of the month the child turns 19 years old.
- For children through the end of the month the child turns 19 years old and under, one pair of eyeglasses per calendar year:
    - Eyeglass lenses — You have a choice in your eyeglass lenses; lenses include factory scratch coating at no additional cost. Covered eyeglass lenses include standard plastic (CR39) lenses up to 55 mm in:
        - Single vision
        - Bifocal
        - Trifocal (FT 25-28)
        - Progressive

        - Contact lenses
    - Basic frames are Covered once every 12 months.

NOTE:

- If a Covered child receives elective or non-elective contact lenses, then no Benefits will be available for eyeglass lenses and frames until you satisfy the Benefit frequency listed above.
- Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under Provider's Office Services - Sickness and Injury provision.

Limitations and Exclusions

The following services are not Covered Health Services or have limitations under the Policy:

- Purchase cost and fitting charge for eyeglasses and contact lenses for adults.
- Implantable lenses used only to correct a refractive error except for implantation of intraocular lenses in conjunction with cataract surgery or lenses used to treat keratoconus.
- Eye exercise or vision therapy and low vision aids.
- Refractions or refractive eye surgery including radial keratotomy. Laser assisted in situ keratomileusis (LASIK), or similar procedures to correct impaired vision that can be corrected with lenses.

SECTION 8: PRESCRIPTION DRUGS

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 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 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 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 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

If your Provider prescribes eye drops for you and the prescription states that refills are needed, you can refill the prescription after 75% of the days have elapsed since your original fill or the date of your last refill. For example, if the prescription is for a 30-day supply, you can refill it after 23 days. If your prescription states that an additional bottle is needed for use in a day care center or school, you 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 12: Appeals, Grievances, and Independent External Review***).

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. In general, specialty drugs will be limited to a 30-day supply at a time. Refer to you Schedule of Benefits for more information.

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 only 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 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 products 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 Product 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 and/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 Step Therapy limit. The P&T Committee has the last word about 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. Your 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 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 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 Member Exception Request Form online or by contacting Member Services. With your consent, such requests may also be submitted on your behalf by your Authorized Representative or by the Provider who prescribed the 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 online by submitting the External Review of a Drug Exception Request by Independent Review Entity form online or by sending the request to CareSource (Common Ground Healthcare) Member Appeals, P.O. Box 1947, Dayton, OH 45401 or calling us at 877-514-2442.

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 your 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 9: Exclusions***, 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.
- Drug or devices that are covered under your Medical Benefit (see ***Section 7: Covered Health Services and Limitations***).
- 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 used for conditions and/or at dosages determined to be Experimental or Investigational unless CareSource has agreed to cover an Experimental or Investigational Service, as defined in ***Section 2: Terms and 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.
- Drugs or devices that are typically administered by a qualified Provider or licensed health professional in an Outpatient setting. These are often paid for under your Medical Benefit. 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.

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 9: EXCLUSIONS

This section includes information on:

- **Exclusions**
- **CareSource does not pay benefits for exclusions**
- **Experimental or investigational or unproven services**

HOW TO USE THIS SECTION

To help you find specific service exclusions more easily, We list those exclusions with the specific service in ***Section 7: Covered Health Services and Limitations***. Go to **Section 7: Covered Health Services and Limitations** to learn more about the exclusions and limitations related to a Covered Health Service.

This Section 9 provides general information on exclusions. It also provides other exclusions that apply generally to services Covered under this Policy. Note that the headings in this section are for clarification and do not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

CARESOURCE DOES NOT PAY BENEFITS FOR EXCLUSIONS

CareSource will not pay Benefits for any of the services, treatments, items or supplies described as exclusions in this Policy, even if either or both of the following are true:

- It is recommended or prescribed by a Provider.
- It is the only available treatment for your condition.

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

EXPERIMENTAL OR INVESTIGATIONAL OR UNPROVEN SERVICES

The following services are not Covered Health Services under the Policy:

- Experimental or Investigational and Unproven Services and all services related to or complications resulting from Experimental or Investigational and Unproven Services. Experimental or Investigational services can be medical, surgical, Diagnostic, psychiatric, Mental Health, Substance Use Disorder or other healthcare services, technologies, supplies, treatments, procedures, drug therapies, medication or devices used for a member's Sickness or Injury. The fact that an Experimental or Investigational or Unproven Service, treatment, device or Pharmacological regimen is the only available treatment for a particular condition or is approved by the FDA (Food and Drug Administration) will not result in Benefits if the procedure falls within the Experimental or Investigational Services definition. They will be considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
- Determination on whether pharmacy services are Experimental, Investigational or Unproven Services is made by CareSource in consultation with a pharmacy and therapeutics review panel consisting of national experts with specialties matching the Pharmaceuticals requested. If the FDA (Food and Drug Administration) has determined the specific use to be contraindicated, or if it 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; it will be considered Experimental and Investigational.

- For medical services, if not recognized as standard of care, We rely on credible, scientific, evidence-based, peer reviewed medical literature with emphasis on articles applying prospective randomized controlled trials to the services requested. When such publications are not available, We contact specialty Providers in the medical community, national physician specialty societies for their position statements on requested services and use well researched national practice guidelines.
- Nothing in this section shall serve to limit a member from enrolling in approved clinical trial (See Covered Services – Clinical Trials).

PERSONAL CARE, COMFORT OR CONVENIENCE

The following services are not Covered Health Services under the Policy:

- Beauty/barber service.
- Concierge medicine.
- Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include but are not limited to:
    - Air conditioners, air purifiers and filters and dehumidifiers.
    - Batteries and battery chargers.
    - Breast pumps, except when required to be Covered as a Preventive Care service in ***Section 7: Covered Health Services and Limitations***.
    - Car seats.
    - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
    - Cold therapy systems.
    - Continuous passive motion devices.
    - Electric scooters.
    - Exercise equipment.
    - Heaters, heating lamps, heating pads.
    - Home modifications such as elevators, handrails and ramps.
    - Hot tubs.
    - Humidifiers
    - Massage equipment, beds, and chairs.
    - Mattresses.
    - Medical alert-jewelry and phone systems.
    - Motorized beds.
    - Music devices.
    - Personal computers.
    - Light fixtures or sun lamps for treatment of Seasonal Affective Disorders or other medical uses. Phototherapy provided for Medically Necessary treatment of certain skin disorders is a Covered Health Service as described in ***Section 7: Covered Health Services and Limitations***.
    - Pillows.
    - Power-operated vehicles and their accessories.
    - Radios.
    - Saunas.
    - Scales.
    - Stair lifts and stair glides.
    - Patient lift systems

- Step stools and standing tables.
- Strollers.
- Safety equipment.
- Special toilet seats and accessories
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

PROVIDERS

The following services are not Covered Health Services under the Policy:

- Health services provided by Out-of-Network Providers or Out-of-Network Facilities except under the Limited Covered Health Services. ***See Section 5: How to Obtain Covered Health Services.***
- Health services provided by Out-of-Network Providers or at Out-of-Network Facilities for which the Out-of-Network Authorization process has not been completed ***See Section 5: How to Obtain Covered Health Services.***
- Any follow-up care related to an urgent or Emergency care service if received from an Out-of-Network Provider. ***See Section 5: How to Obtain Covered Health Services.***
- Services performed by an Out-of-Network Provider for care that is neither Urgent Care nor Emergency care without an approved referral, except where expressly allowed under this Certificate.
- Urgent Care services obtained through an Out-Of-Network Urgent Care Center that is within the Service Area.
- Services 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 a spouse, brother, sister, parent, or child. This includes any service the Provider may perform on himself or herself.
- Services provided at a free-standing or Hospital-based Diagnostic facility without an order written by a qualified In-Network Practitioner are not Covered. Services which are self-directed to a free-standing or Hospital-based Diagnostic facility are not Covered. Services ordered by a Provider or other Provider who is an employee or representative of a free-standing or Hospital-based Diagnostic facility are not Covered, when that Provider or other Provider 1) has not been actively involved in your medical care prior to ordering the service, or 2) Is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.
- Services provided by a doula or similar Practitioner that is not a CareSource credentialed health care Provider.
- Services provided by a health coach that is not a CareSource-credentialed health care Provider.

SERVICES PROVIDED UNDER ANOTHER PLAN

The following services are not Covered Health Services under the Policy:

- Health services for which other coverage is required by Federal, state or local law to be purchased or provided through other arrangements. Examples include health services for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which Benefits are available or would have been required 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, traditional auto insurance, or similar legislation.
- Health services paid for by other insurance or medical coverage, including, but not limited to,

health services for treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health services while on active military duty.

TRAVEL

The following services are not Covered Health Services under the Policy:

- Any immunizations for the sole purpose of traveling outside of the United States.
- Health services provided in a foreign country, unless required as Emergency Health Services. These Emergency Health Services do NOT include transportation expenses necessary to return you to the United States.
- Travel or transportation expenses, even though prescribed by a Provider. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Provider may be reimbursed at CareSource's discretion. This exclusion does not apply to ambulance transportation for Benefits provided as described under Ambulance Services in ***Section 7: Covered Health Services and Limitations***.

TYPES OF CARE

The following services are not Covered Health Services under the Policy:

- Multi-disciplinary pain management programs provided on an Inpatient basis for acute pain or for exacerbation of chronic pain.
- Custodial Care, domiciliary care or maintenance care or therapy.
- Private Duty Nursing nor services of personal care attendants.
- Home health aides. This exclusion does not apply to home health aides that are part of an integrated hospice care program provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in **Section 7: Covered Health Services and Limitations**
- Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in ***Section 7: Covered Health Services and Limitations.***
- Rest cures.
- Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).
- Concierge medicine.
- Executive health programs.
- Medical tourism.

ALL OTHER EXCLUSIONS

The following services are not Covered Health Services under the Policy:

- Bariatric surgery, including gastric restrictive, bypass, and other similar surgeries, and treatment of any related complications.
    - This exclusion applies regardless of the diagnosis or the reason for the surgery.
- Weight loss or weight control programs, services and surgeries for the treatment of obesity, including bariatric surgery.

- Also excluded from coverage are complications that are related to any of these programs, services, treatments or surgeries.
    - This exclusion does not include any weight loss or weight control services that are required by law to cover.
- Services or equipment to prevent Injury.
- Services or equipment to help or make physical activity or sports possible.
- Services to prevent Illness, except those services expressly listed in Preventive Care under ***Section 7: Covered Health Services and Limitations,*** or that CareSource is required to cover by law.
- Services or items for physical fitness, wellness, health education or personal hygiene.
- Services to educate or help adapt to a diagnosis or a chronic physical or Mental Illness. Examples include:
    - Stress management classes; and
    - Classes, education and awareness training for individuals suffering from chronic pain.
- In the absence of an Illness or Injury, services to help improve existing physical or Mental Health and sense of wellbeing.
- Removal and treatment of skin tags.
- Services for which the sole purpose is to improve appearance. Examples include, but are not limited to:
    - Services to improve skin appearance.
    - Cosmetic Surgery.
    - Services to treat and/or remove keloids.
    - Services to repair scarring or disfigurement caused by body piercing, tattooing, or implants.
    - Other services or procedures which were not Medically Necessary, appropriate or performed by a licensed medical professional.
- Services for male or female baldness or hair loss, regardless of the cause. This includes, but is not limited to:
    - Hair restoration;
    - Hair transplants; and
    - Hair implants.
- Services or supplies intended primarily for convenience or personal preference.
- Services or interventions that have not been documented as being safe and effective for a specific Illness or Injury.
    - This exclusion applies even if the service or intervention was or will be potentially helpful.
    - Examples include, but are not limited to:
        - Acupuncture
        - Acupressure
        - Alternative nutritional therapy
        - Aromatherapy
        - Ayurvedic medicine
        - Bioelectromagnetic therapy
        - Bio energetic synchronization technique (BEST)
        - Colonic irrigation
        - Contact reflex analysis
        - Energetic therapy (e.g., Reiki)
        - Guided imagery
        - Herbal medicine

  - Holistic medicine
  - Homeopathy
  - Hypnosis and hypnotherapy
  - Iridology
  - Macrobiotics
  - Magnetic innervation therapy
  - Manual healing
  - Meditation
  - Mind/body control therapy
  - Naturopathy
  - Neurofeedback
  - Orthomolecular therapy
  - Reflexology
  - Relaxation techniques
  - Sensory integration therapy
  - Services provided by a massage therapist
  - Sleep therapy
  - Traditional and/or ethnomedicine therapy
  - Yoga
- Custodial or Long-Term Care.
- Any services you get after your health condition has stabilized and you have reached the expected level of improvement or resolution.
- Holistic or homeopathic remedies and preparations.
- Any services received due to complications suffered after leaving a licensed medical facility against the advice of medical professionals.
- Any services as a result of complications of a non-Covered service.
- Any services which are not documented in the Provider's records.
- Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasties and brachioplasties (arm lifts). Non-Cosmetic removal of pannus (panniculectomy) may be deemed Medically Necessary.
- Medical and surgical treatment of excessive sweating (primary hyperhidrosis).
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. A sleep study is required for documentation.
- Psychosurgery.
- Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- Biofeedback except Covered items in ***Section 7: Covered Health Services and Limitations.***
- Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment including Leforte I, II, sagittal split/mandibular body, mentoplasty, and similar osteotomies that are customary and coincident to orthognathic treatment or to solely improve the Cosmetic appearance and dentofacial disharmony, or for treatment of dental malocclusion. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer, obstructive sleep apnea or temporomandibular joint disorder.
- Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care Providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive

psychological support, behavior modification techniques and medications to control cravings.

- Breast reduction that is not deemed Medically Necessary and does not meet Medical Necessity criteria.
- Vitamins.
- Nutritional or diet supplements, except for those required by law to cover.
- Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in ***Section 2: Terms and Definitions***.
- Physical, behavioral health exams, testing, immunizations or treatments that are otherwise Covered under the Policy when:
    - Required solely for purposes of school (including return to school), sports or camp participation, travel, career or employment (including return to employment), insurance, marriage or adoption or required to obtain or maintain a license of any type.
    - Related to judicial or administrative proceedings or orders. **Note:** This exclusion does not apply if the services are provided as the result of an Emergency detention, commitment or court order as required under Wisconsin Statutes Section 609.65, Coverage for Court-Ordered Services for the Mentally Ill.
    - Conducted for the purposes of medical research. This exclusion does not apply to services or supportive care associated with the actual clinical trial.
- Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in ***Section 7: Covered Health Services and Limitations***.
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
- Health services received before your Effective Date or after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
- Health services for which you have no legal responsibility to pay, for which a charge would not ordinarily be made in the absence of coverage under the Policy, or for which a Provider, Pharmaceutical manufacturer or similar entity pays a portion of the charge. This includes any financial assistance including coupons, savings cards, grants, special programs or gift/cash cards you may receive. Such amounts will not be credited to your Deductible, Coinsurance or Maximum Out-of-Pocket limit unless required by State and/or Federal law.
- Health services for which billing is not received by CareSource within one (1) year from the time proof is otherwise required.
- In the event an Out-of-Network Provider waives Copayments, Coinsurance and/or any Deductible for a particular health service, no Benefits are due to be applied for the health service for which the Copayments, Coinsurance and/or Deductible are waived.
- Reimbursement of Eligible Expenses or expenses that exceed any specified limitation, including the Maximum Allowed Amount.
- Reimbursement for which Benefit coverage cannot be determined because a Covered Person, Provider, facility, or other individual or entity failed to provide within 30 days:
    - Authorization of medical records or other information as requested.
    - Requested information about pending Claims or other insurance coverage.
    - Information as required by any contract with Us or a network including, but not limited to, repricing information.
    - Information that is accurate and complete.

- Long-term (more than 30 days) storage of body fluids and/or tissue. Examples include cryopreservation of tissue, blood, or cellular components.
- Autopsy.
- Biliary lithotripsy.
- Chemonucleolysis.
- Dry needling, prolotherapy.
- Treatment of telangiectatic dermal veins and sclerotherapy and any related services.
- Allergy testing. Testing includes, but is not limited to, scratch tests or specified intradermal tests, specific laboratory tests to determine respiratory function and serum (blood) levels related to the immune system.
- Coma stimulation programs.
- Court ordered care unless services are already Covered under this Certificate. Note: This exclusion does not apply if the services are provided as the result of an Emergency detention, commitment or court order as required under Wisconsin Statutes Section 609.65, Coverage for Court-Ordered Services for the Mentally Ill.
- Foreign language and sign language services in a clinical setting including a medical Provider's office or other facility. Reasonable foreign language and sign language services will be provided by Us when needed to communicate with members regarding Benefits.
- Evaluation and Management related to non-Covered Health Services: When services are not deemed Covered Health Services, all reimbursement related to such services are also excluded. This exclusion includes health care to treat complications that arise from non-Covered Health Services. Examples of "complications" would include bleeding or infections, following a Cosmetic or Experimental /Investigational procedure.
- Neuropsychological testing when not considered Medically Necessary.
- Chimeric Antigen Receptor (CAR) T-cell therapy and/or gene therapy, including allogenic processes, glandular organs, and any related services, items, and/or drugs as well as any future therapies within these drug groups.

SECTION 10: COORDINATION OF BENEFITS

This section includes information on:

- **Benefits when you have coverage under more than one plan**
- **Coordination of benefit provisions impacting those eligible for Medicare**
- **Right to receive and release needed information**
- **Payments made**
- **Right of recovery**

BENEFITS WHEN YOU HAVE COVERAGE UNDER MORE THAN ONE PLAN

This section describes how Benefits under the Policy will be coordinated with those of any other plan when you or another Covered Person have Benefits under any other policy or plan that provides coverage or services for medical, pharmacy or dental care or treatment to a Covered Person. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating Benefits.

TERMS AND DEFINITIONS SPECIFIC TO THIS SECTION

Primary Plan: When you or another Covered Person have more than one policy or plan, the plan that is required to pay first is called a Primary Plan.

- A Primary Plan **may** include:
    - group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of Long-Term Care contracts, such as Skilled Nursing care; medical Benefits under group or individual automobile contracts; and Medicare or any other Federal governmental plan, as permitted by law.
- A Primary Plan **does not** include:
    - Hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited Benefit health coverage, as defined by state law; school accident type coverage; Benefits for non-medical components of Long-Term Care policies; Medicare supplement policies; Medicaid policies; or coverage under other Federal governmental plans, unless permitted by law.

Any policy that falls under either bullet above is a separate plan. If a plan has two parts and coordination of Benefits rules apply only to one of the two, each of the parts is treated as a separate plan. You must notify Us if you have any other coverage that constitutes a plan under any other policy or plan that provides coverage or services for medical, pharmacy or dental care or treatment to a Covered Person.

Allowable Expense: A health care expense, including Deductibles, Copayments and/or Coinsurance, that is Covered at least in part by any Primary Plan and your CareSource Policy. 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 or services that are not Allowable Expenses:

- The difference between the cost of a Semi-Private Hospital Room and a private room is not an Allowable Expense unless one of the plans provides coverage for private Hospital room expenses.

- If a person is Covered by two 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.
- If a person is Covered by two or more plans that provide Benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- If the Primary Plan calculates its Benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, the Primary Plan's payment arrangement shall be the Allowable Expense for both plans.
- The amount of any Benefit reduction by the Primary Plan because a Covered Person has failed to comply with the plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred Provider arrangements.

Closed Panel Plan: A plan that provides health care Benefits to Covered Persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the plan, and that excludes Benefits for services provided by other Providers, except in cases of Emergency or referral by an In-Network Provider and approved by Us.

Custodial Parent: 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 plans, the rules for determining the order of Benefit payments are as follows:

- The Primary Plan pays or provides its Benefits according to its terms of coverage and without regard to the Benefits under any other plan.
- Except as provided in the next paragraph, a plan that does not contain a coordination of Benefits provision that is consistent with this provision is always primary unless the provisions of both plans state that the complying plan is primary. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of Benefits and provides that this supplementary coverage shall be in excess of any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical Benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network Benefits.
- A plan may consider the Benefits paid or provided by another plan in determining its Benefits only when it is secondary to that other plan.
- Each plan determines its order of Benefits using the first of the following rules that apply:
    1. Non-Dependent or Dependent. The plan that covers the person other than as a Dependent, for example as an employee, member, policyholder, Subscriber or retiree is the Primary Plan and the plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the plan covering the person as a Dependent, and primary to the plan covering the person as other than a Dependent (e.g., a retired employee), then the order of Benefits between the two plans is

reversed so that the plan covering the person as an employee, member, policyholder, Subscriber or retiree is the secondary plan and the other plan is the Primary Plan.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a Dependent child shall determine the order of Benefits 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 plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
        ii. If both parents have the same birthday, the plan that Covered the parent longest is the Primary Plan.
    b. For a Dependent child whose parents are divorced or separated or are 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 plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the Dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which Benefits are paid or provided before the entity has actual knowledge of the court decree provision.
        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 2(a) above shall 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 2(a) shall determine the order of Benefits.
        iv. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of Benefits for the child are as follows:
            1. The plan covering the Custodial Parent
            2. The plan covering the Custodial Parent's spouse
            3. The plan covering the non-Custodial Parent
            4. The plan covering the non-Custodial Parent's spouse
    c. For a Dependent child Covered under more than one plan of individuals who are not the parents of the child, the order of Benefits shall be determined, as applicable, under subparagraph (a) or (b) above as if those individuals were parents of the child.
3. Active Employee or Retired or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The 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 plan does not have this rule, and, as a result, the plans do not agree on the order of Benefits, this rule is ignored.
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 plan, the plan covering the person as an employee, member, Subscriber or retiree or covering the person as a Dependent of an employee, member, Subscriber or retiree is the Primary Plan, and the COBRA, or state or other Federal continuation coverage

is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of Benefits, this rule is ignored.

5. Longer or Shorter Length of Coverage. The plan that Covered the person as an employee, member, policyholder, Subscriber or retiree longer is the Primary Plan and the plan that Covered the person the shorter period of time is the secondary plan.
6. If the preceding rules do not determine the order of Benefits, the Allowable Expenses shall be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

CareSource may reduce Benefits under the provisions of this Certificate, so that the total Benefits paid or provided by all plans are not more than the total Allowable Expenses. If CareSource is the secondary plan, We will calculate the Benefits that would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense that is unpaid by the Primary Plan. We may then reduce the payment by an amount so that, when combined with the amount paid by the Primary Plan, the total Benefits paid or provided by all plans for the Claim do not exceed the total Allowable Expense for that Claim.

If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel Provider, Benefits are not payable by one Closed Panel Plan, coordination of Benefits shall not apply between that plan and other Closed Panel Plans.

COORDINATION OF BENEFIT PROVISIONS IMPACTING THOSE ELIGIBLE FOR MEDICARE

CareSource reduces its Benefits as described below for Covered Persons who are enrolled in Medicare when Medicare is the Primary Plan. If a Covered Person has other health insurance which is determined to be primary to Medicare, then Benefits will be based on Medicare's reduced Benefits. In no event will the combined Benefits paid under your CareSource Policy exceed the total Medicare Eligible Expense for the service or item.

Medicare Benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is enrolled in a Medicare Advantage (Medicare Part C) Plan and receives non-Covered Health Services because the person did not follow all rules of that Plan. Medicare Benefits are determined as if the services were Covered under Medicare Parts A and B.
- The person receives services from a Provider who has elected to opt-out of Medicare. Medicare Benefits are determined as if the services were Covered under Medicare Parts A and B and the Provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a veterans administration facility, facility of the uniformed services, or other facility of the Federal government. Medicare Benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a Medicare medical savings account. Medicare Benefits are determined as if the person were Covered under Medicare Parts A and B.

Benefits under your CareSource Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.

If you are eligible for or enrolled in Medicare, please read the following information carefully: If you are

eligible for Medicare on a primary basis (Medicare pays before Benefits under the CareSource Policy), you should enroll in and maintain coverage under both Medicare Part A and Part B.

If you are enrolled in a Medicare Advantage (Medicare Part C) Plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that Plan that require you to seek services from that Plan's participating Providers. When CareSource is the secondary payer, CareSource will pay any Benefits available to you under the Policy as if you had followed all rules of the Medicare Advantage Plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health insurance coverage and services are needed to apply the coordination of Benefits rules and to determine Benefits payable under this Plan and other plans. CareSource may get the facts We need from, or give them to, other organizations or persons to apply these rules and determine Benefits payable under this Plan and other plans covering the person claiming Benefits. You must cooperate with Us by providing the information necessary to adjudicate your Claims. Failure to do so may result in delay and Claim denial.

We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Plan must give Us any facts We need to apply those rules and determine Benefits payable. If you do not provide the information We need to determine the Benefits payable, your claim for Benefits will be denied.

PAYMENTS MADE

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, We may pay that amount to the organization that made the payment. That amount will then be treated as though it were a Benefit paid under the CareSource Plan. We will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means reasonable cash value of the Benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payment CareSource made is more than the amount that should have paid under this coordination of Benefits provision, CareSource may recover the excess from one or more of the persons CareSource has paid or for whom CareSource has paid or any other person or organization that may be responsible for the Benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

SECTION 11: GENERAL LEGAL PROVISIONS

This section includes information on:

- **Your relationship with CareSource**
- **Relationships with Providers**
- **Subrogation and reimbursement**
- **Other important information**

YOUR RELATIONSHIP WITH CARESOURCE

To make choices about your health care coverage and treatment, We believe that it is important for you to understand how your Policy works. We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Provider make those decisions.
- We communicate to you, decisions about whether your Policy will cover or pay for the health care that you may receive. The Policy pays for Covered Health Services, which are more fully described in this Certificate.
- The Policy may not pay for all treatments you or your Provider may believe are necessary. If the Policy does not pay, you may be responsible for the cost.

We may use information about you to identify procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in Our operations and in Our research. We will use de-identified data for commercial purposes including research.

CARESOURCE'S RELATIONSHIP WITH PROVIDERS

We do not provide health care services or supplies, nor do We practice medicine. Instead, We enter into agreements with Providers and We pay them to provide Covered Health Services. These In-Network Providers run their own offices and facilities. Our credentialing process confirms public information about the Providers' licenses and other credentials but does not assure the quality of the services provided. They are not CareSource employees nor does CareSource have any other relationship with In-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.

- You are responsible for choosing your own Provider.
- You are responsible for paying, directly to your Provider, any amount identified as a member's responsibility, including any Deductible, Copayments and/or Coinsurance, and any amount that exceeds the Maximum Allowed Amount. For Balance Billing, see ***Section 2: Terms and Definitions*** **and** ***Section 5: How to Obtain Covered Health Services***.
- You are responsible for paying, directly to your Provider, the cost of any non-Covered Health Service.
- You must decide if any Provider treating you is right for you. This includes In-Network Providers you choose and Providers to whom you have been referred.

- You must decide with your Provider what care you should receive.
- Your Provider is solely responsible for the quality of the services provided to you.

STATEMENTS BY SUBSCRIBER

All statements made by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, CareSource will not use any statement made by a Subscriber to void the Policy after it has been in force for a period of two years.

INCENTIVES TO PROVIDERS

CareSource pays In-Network Providers through various types of contractual arrangements, some of which may include financial incentives 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. These incentives may also be designed to comply with the Quality Improvement Strategy provision of the Affordable Care Act.

CareSource uses various payment methods to pay specific In-Network Providers. From time to time, the payment method may change. If you have questions about whether your In-Network Provider's contract with CareSource includes any financial incentives, We encourage you to discuss those questions with your Provider. CareSource can advise whether your In-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.

INCENTIVES AND SERVICES OFFERED TO YOU

Sometimes CareSource may offer 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 alone, and We recommend that you discuss participating in such programs with your Provider. In addition, We may offer free or discounted access to services, discount programs, or other incentives to help you stay well. These incentives and services are not Benefits and do not alter or affect your Benefits. They can be discontinued at any time. Contact Us if you have any questions.

REBATES AND OTHER PAYMENTS

CareSource may receive rebates for certain drugs that are administered to you in your home or in a Provider’s office, or at a Hospital. This includes rebates for those drugs that are administered to you before you meet any applicable Deductible. We do not pass these rebates on to you, nor are they applied to any Deductible or taken into account in determining your Copayments or Coinsurance.

INTERPRETATION OF BENEFITS

CareSource has the sole and exclusive discretion to do all the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations, and exclusions set out in the Policy, including this Certificate, the Schedule of Benefits, and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

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

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

ADMINISTRATIVE SERVICES

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

AMENDMENTS TO THE POLICY

To the extent permitted by law, CareSource reserves the right, in Our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits, or terminate the Policy.

Any provision of the Policy which, on its Effective Date, conflicts with the requirements of state or Federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of CareSource officers.

All the following conditions apply:

- Amendments to the Policy are effective 31 days after We send written notice to the Subscriber.
- Amendments that result in a reduction of Benefits will be effective 60 days after prior written notice.
- Riders are effective on the date We specify.
- No Agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or Amendments to the Policy.

INFORMATION AND RECORDS

CareSource may use your individually identifiable health information to administer the Policy and pay Claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. CareSource will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law.

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

Failure to cooperate in obtaining information necessary to properly adjudicate your Claims may result

in delay and denial of those Claims. This applies to all Benefit determinations, including those for coordination of Benefits and subrogation.

We have the right to release all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as We are required to do by law or regulation. During and after the term of the Policy, CareSource and Our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements We recommend you contact your health care Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

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

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

CONFORMITY WITH FEDERAL AND STATE LAWS

CareSource complies with all applicable state and Federal laws. This Certificate will conform with the minimum requirements of all applicable laws if there is no governing Certificate provision or a conflicting Certificate provision. Regarding time frames in this Certificate: if the minimum or maximum legal requirement is changed following the issuance of this Certificate, We have the right to apply the minimum legal requirement.

SECOND OPINION AND MEDICAL EXAMINATION OF COVERED PERSONS

One second opinion per Injury or Illness by an In-Network Provider is Covered regarding Covered Health Services. Prior Authorization for the second opinion must be obtained when it is required as described in ***Section 6: Prior Authorization & Hospital Admission Notification.*** An Out-of-Network Authorization is required if a second opinion is requested for an Out-of-Network Provider. ***See Section 5 under Limited Covered Health Services from Out-of-Network Providers.*** CareSource reserves the right to require an ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review, or similar programs at CareSource's expense to determine whether the service or supply meets the definition of a Covered Health Service.

WORKERS' COMPENSATION NOT AFFECTED

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

SUBROGATION AND REIMBURSEMENT

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, We shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any

services and Benefits We provided to you, from any or all of the following listed below. In addition to any subrogation rights and in consideration of the coverage provided by this Certificate, We shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits We provide to you, from any or all the following listed below.

- Third parties, including any person alleged to have caused you to suffer Injuries or damages.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory. These third parties and persons or entities are collectively referred to as "third parties".

You agree as follows:

- That you will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement, including:
    - Providing any relevant information requested by Us.
    - Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement Claim.
    - Responding to requests for information about any accident or Injuries.
    - Making court appearances.
    - Obtaining Our consent or Our agent's consent before releasing any party from liability or payment of medical expenses.
- That We have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorney's fees may be deducted from Our recovery without Our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and We are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal Injury Claim.
- That after you have been fully compensated or made whole, We may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That Benefits paid by Us may also be considered Benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an Injury or Illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed a breach of your duties hereunder.
- That We may set off from any future Benefits otherwise provided by Us the value of Benefits paid or advanced under this section to the extent not recovered by Us.
- That you will not accept any settlement that does not fully compensate or reimburse Us without Our written approval, nor will you do anything to prejudice Our rights under this provision.
- That you will assign to Us all rights of recovery against third parties, to the extent of the reasonable value of services and Benefits We provided, plus reasonable costs of collection.
- That Our rights will be considered as the first priority Claim against third parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your Claims are paid.
- That We may, at Our option, take necessary and appropriate action to preserve Our rights under

these subrogation provisions, including filing a lawsuit in your name, which does not oblige Us in any way to pay you part of any recovery We might obtain.

- That We shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate, and your heirs, assigns, or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a Claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that Claim.

REFUND OF OVERPAYMENTS

If CareSource pays Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to Us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment We made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

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

We may also choose to recover overpayments by offsetting the overpayment from a future payment made to the overpaid Provider. If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, We may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future Benefits.

LIMITATION OF ACTION

CareSource encourages you to complete all the steps in the Appeal process described in ***Section 12: Appeals, Grievances, and Independent External Review*** as an effective way of resolving disputes on a timely basis.

ENTIRE POLICY

The Policy issued to the Subscriber, including this Certificate, the application, the Schedule of Benefits, and any Riders and/or Amendments, constitutes the entire Policy.

ASSIGNMENT OF BENEFITS

This coverage is just for you, the Subscriber, and/or your Dependents. Benefits may be assigned to a Provider to the extent allowed by Wisconsin insurance law and by other provisions in this Certificate.

NON-DISCRIMINATION

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

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as 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 877-514-2442 TTY: 711.

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a Grievance, with: CareSource Attn: Civil Rights Coordinator P.O. Box 1947, Dayton, Ohio 45401 1-844-539-1732, TTY: 711 Fax: 1-844-417-6254 CivilRightsCoordinator@CareSource.com.

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

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

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

- Reconstruction of the breast on which the mastectomy has been performed;

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

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

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.

SECTION 12: APPEALS, GRIEVANCES, AND INDEPENDENT EXTERNAL REVIEW

This section includes information on:

- **Complaints**
- **Appeal/Grievance Process**
- **Independent External Review**
- **Office of the Commissioner of Insurance**

COMPLAINTS

A **COMPLAINT** is a verbal expression of dissatisfaction with CareSource or any In-Network Provider. If you have a Complaint, please contact the Member Services Department shown on your ID card. A Member Services representative will work with you to try to resolve your Complaint to the extent possible. If you are not satisfied with the resolution of your Complaint, then you may file a Grievance.

APPEAL/GRIEVANCE PROCESS

A **GRIEVANCE** is any written Complaint or dispute expressing dissatisfaction with any aspect of CareSource operations or activities or that of any In-Network Provider. A Grievance could include written Complaints regarding the provision of services, billing, concerns related to equity or discrimination, fraud waste and abuse, Privacy/HIPAA violations, and many other things.

When you or an Authorized Representative asks CareSource in writing to review any Adverse Benefit Determination or Rescission of Coverage, it is called an Appeal. Examples of a reason for Appeal may be that your Prior Authorization request for a particular Prescription Drug or surgical procedure was denied.

You, or your Authorized Representative, may file an Appeal or Grievance with CareSource within three years after the date your Claim was processed, or you were advised of an Adverse Benefit or medical Determination, or Rescission of Coverage. The Appeal/Grievance may involve CareSource's administration or Claim practices (including a denial of a Claim you think should be paid by CareSource), Adverse Benefit Determinations regarding the levels of Benefits available, or the provision of services provided to you.

The Appeal/Grievance will be evaluated by the Member Appeal and Grievance Committee and a response will be made to you within 30 calendar days, or sooner, depending on the urgency of the Appeal/Grievance request.

The Appeal/Grievance can be submitted in any of the following ways:

- Log into the Member Portal at MyLife.CareSource.com
- Mail to:

  CareSource
  ATTN: Member Appeals & Grievances
  PO Box 1947 Dayton, OH 45401

CareSource will acknowledge receipt of the Appeal/Grievance within five business days of receipt and the Appeal/Grievance will be added to the agenda of a scheduled meeting of Our Member Appeal and Grievance Committee. You will be advised of your right to submit written comments, documents, or other information regarding your Appeal, your right to join the committee meeting and/or be assisted or represented by another person of your choice by completing an Authorized Representative Form, the

availability of interpreter services, and how to contact Us for scheduling or more information.

No fewer than seven calendar days prior to the meeting, you will be notified of the date and time in case you would like to present your Appeal/Grievance in person, via teleconference, and/or video conference. We will provide you with any new or additional evidence considered, relied upon, or generated by Us in connection with the Appeal/Grievance. We will send you a written determination of the Appeal/Grievance within 30 calendar days of receipt of the Appeal/Grievance. If special circumstances require a longer review period, We may request an additional 14 calendar days to make a decision. If We need the extra days, We will notify you of the reason why and when a decision may be expected.

EXPEDITED APPEAL/GRIEVANCE REQUEST

You may make a written or oral request for an Expedited Appeal/Grievance if:

- An Adverse Benefit Determination that involves a medical condition for which the timeframe for completion of a standard Internal Review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function based on a prudent layperson's judgment, or
- In the opinion of a Qualified Practitioner with knowledge of your medical condition determines that the Appeal should be treated as an Expedited Appeal, or
- If the Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you have received services, but have not been discharged from the facility and you or your designee have filed a request for an Internal Review.

Once We receive all the information needed to make a determination, an expedited request will be resolved within 24 hours for urgent, concurrent Appeal/Grievance requests, and as soon as possible, but no later than 72 hours for urgent, pre-service Appeal/Grievance requests.

INDEPENDENT EXTERNAL REVIEW PROGRAM

When CareSource has denied an Appeal and you have exhausted the internal Appeals Process (outlined above), an Independent External Review is available to you within four months after We send you the final notice of Adverse Benefit Determination or Rescission of Coverage. To qualify for Independent External Review process, your situation or issue must involve an Adverse Benefit Determination based on the following:

- Medical judgment (for example: Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, or Experimental and Investigational treatments); or
- Our denial of your request for Out-Of-Network Services when you believe that the clinical expertise of the Out-of-Network Provider is Medically Necessary (but only if the treatment or service would otherwise be a Covered Benefit under your Plan), or
- A Rescission of Coverage (whether or not the rescission has any effect on any particular Benefit at that time).

In most cases, you must have completed the Appeal/Grievance process prior to requesting an Independent External Review. Exceptions are:

- Both CareSource and you agree that the matter may proceed directly to Independent External Review or you need immediate medical care or services. If this is the case, you may submit an Expedited Independent External Review request (see below) if you believe that the time period for resolving an Appeal/Grievance would cause a delay that could jeopardize your life or health; or
- CareSource failed to adhere to all the requirements of the Appeal Process. Then you are deemed

to have exhausted the internal Claims and Appeals process and can proceed to Independent External Review unless such failure is de minimus and non-prejudicial to you, attributable to good cause or matters beyond CareSource's control, in the context of an ongoing, good faith exchange of information between you and Us, and not reflective of a pattern or practice of non-compliance by Us.

You may not request an Independent External Review if:

1. The requested treatment is not a Covered Health Service under this Certificate;
2. The decision involves contractual or legal interpretation without any use of medical judgment; or
3. For administration issues such as the application of amounts to your Deductible.

HOW TO REQUEST AN INDEPENDENT EXTERNAL REVIEW

You must submit a request within four months after the date you receive a notice that CareSource denied your Appeal. If there is no corresponding date four months after the date you receive a notice, then the request must be filed by the first day of the fifth month after receipt of the notice. For example, if the date you receive the notice is October 30, because there is no February 30, the request must be filed by March 1.

Requests must be submitted by one of the following ways:

- online at https://externalappeal.cms.gov/ under the "Request a Review Online" heading;
- by faxing a written request to 888-866-6190; or
- by mail, addressed to:

  MAXIMUS Federal Services
  3750 Monroe Avenue, Suite 705, Pittsford, NY 14534.

The request should include your name, address, and phone number, the reason you disagree with CareSource's decision, including any documents that support your position. Please include a statement authorizing your representative to pursue Independent External Review on your behalf if you choose to use one.

HOW TO FILE AN EXPEDITED INDEPENDENT EXTERNAL REVIEW

If you believe your case should be expedited, you can select "expedited" if submitting the review request online, by emailing FERP@maximus.com, or by calling Federal External Review Process at 888-866-6205 ext. 3326. If you have any questions or concerns during the external review process, please call the toll-free number at 888-866-6205.

You may make a written or oral request for an Expedited Independent External Review if:

- An Adverse Benefit Determination that involves a medical condition for which the timeframe for completion of a standard Independent External Review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; and
- If the Adverse Benefit Determination or Rescission of Coverage concerns an admission, availability of care, continued stay, or health care item or service for which you have received services, but have not been discharged from the facility and you or your designee have filed a request for an Expedited Independent External Review. The Expedited Independent External Review examiner will provide notice of his/her decision as expeditiously as the medical circumstances require, but in no event longer than 72 hours after the request for an Expedited Independent External Review. If you are in an Urgent Care situation and are also in an ongoing course of treatment for that condition, a decision will be provided within 24 hours of receipt and acknowledgement that your

case meets the criteria for Expedited Independent External Review.

Notice of the decisions may be provided as quickly as medical circumstances require, but no later than within 72 hours of receiving the request.

MAXIMUS can give the external review decision orally, but it must be followed up by a written version of the decision within 48 hours of the oral notification.

OFFICE OF THE COMMISSIONER OF INSURANCE

You can use the Grievance process described above to address any concerns or Complaints you may have. If you are not satisfied with CareSource's Grievance decision, you may also contact the Office of the Commissioner of Insurance, a state agency which enforces Wisconsin's insurance laws, and file a Complaint. You can contact the Office of the Commissioner of Insurance by:

- Writing to:
  Office of the Commissioner of Insurance Complaints Department
  P.O. Box 7873
  Madison, WI 53707-7873
- Or you can call 800-236-8517 (outside of Wisconsin) or 608-266-0103 (in Wisconsin)
- Fax them at 608-264-8115
- Email them at ocicomplaints@wisconsin.gov and request a complaint form.
- Complete a complaint form online at https://oci.wi.gov/Pages/Consumers/Filing-a-Complaint.aspx.