

CareSource
Evidence of Coverage
and Health Insurance Contract

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CareSource Kentucky Co.

10200 Forest Green Blvd
Suite 400
Louisville, Kentucky 40223
502-213-4700, 1-888-815-6446

KENTUCKY REQUIRED COVER SHEET

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

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

CareSource is not a member of any guaranty fund. In the event of CareSource's insolvency, you are not financially responsible for Health Care Services that you received from a Network Provider. In the event of CareSource's insolvency, you may have to pay for Health Care Services you receive from a Non-Network Provider, whether or not CareSource authorized the use of the Non-Network Provider.

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Dear CareSource Member,

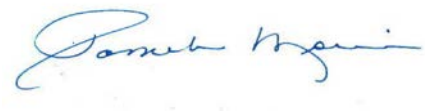
Thank you for trusting CareSource as your health plan! CareSource was founded as a non-profit managed care company over 25 years ago. Our mission is to make a difference in peoples' lives by improving their health care. It is the essence of our company and our unwavering dedication to that mission is a hallmark of our success.

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

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

Thank you for choosing CareSource. We look forward to serving you and your health needs. If you have any questions or concerns about your health care or your coverage under the Plan, please call us at 1-888-815-6446.

Sincerely,



Pamela B. Morris
President and Chief Executive Officer
CareSource Kentucky Co.

SECTION 1 – WELCOME

This section includes information on:

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

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

How to Contact Us

How to Contact CareSource:

- Member Services, Benefit inquiries, and other questions: 1-888-815-6446;
- Pharmacy Drug Benefit Related Questions: 1-888-815-6446;
- CareSource24®, our 24-hour nurse advice line: 1-866-206-7879;
- Online assistance: CareSource.com/marketplace
- CareSource mailing address: P.O. Box 824, Dayton, Ohio 45401; and
- For information on how to make payments see Section 2: *How the Plan Works*.

Throughout this document, you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call Member Services. It will be our pleasure to assist you.

How to Use Your Evidence of Coverage

How to Use This EOC:

- Read the entire EOC. Then keep it in a safe place for future reference.
- Many of the sections of this EOC are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your EOC and any future Riders/Enhancements or Amendments at CareSource.com/marketplace or request printed copies by contacting Member Services.
- Capitalized words in this EOC have special meanings and are defined in Section 13: *Glossary*.
- CareSource is also referred to as the Plan.

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

Defined Terms

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

Your Responsibilities

Be Enrolled and Pay Required Premiums

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

Choose Your Health Care Providers

It is your responsibility to select the Network Providers and Network Pharmacies that will provide your health care. We can assist you to find Network Providers and Network Pharmacies. We will not cover Health Care Services provided by a Non-Network Provider except as provided in Section 2: *How the Plan Works, Services Provided by Non-Network Providers, and Continuity of Care for New Covered Persons;* Section 3: *Coverage for Urgent Care Services Outside the Service Area,* and *Inpatient Hospital Services*; and Section 4: *Your Covered Benefits, Emergency Health Care Services.* For more information on choosing your Network Providers, please see Section 2: *How the Plan Works, Choose a PCP.*

Your Financial Responsibility

You must pay Copayments, Coinsurance, and the Annual Deductible for most Covered Services. See Section 2: *How the Plan Works* and Section 14: *Schedule of Benefits* for further detail on your Copayments, Coinsurance, and Annual Deductible obligations. The exact amount of the Copayments, Coinsurance, and Annual Deductible for which you are responsible is listed in Section 14: *Schedule of Benefits.*

If you are a member of a federally recognized tribe and your household income is at or below 300% of the federal poverty level, you will have no cost sharing (including Copayments, Coinsurance, and Deductibles) for Covered Services. More information, including a list of federally recognized tribes, is available online at: http://www.healthcare.gov. Regardless of your household income, there is no cost sharing if you receive services from an Indian health care provider or through referral under the Contract Health Care Services program administered by the Indian Health Service.

Pay the Cost of Limited and Excluded Services

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

Show Your ID Card

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

Don't Forget Your ID Card

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

The Marketplace

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

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

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

Eligibility Requirements

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

- Are a citizen of the United States or a lawfully present immigrant;
- Are not incarcerated for a felony conviction; and
- Are a resident of the Commonwealth of Kentucky and reside within the Plan's Service Area.

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

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

Dependents who are eligible to participate in the Plan include:

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

   To qualify as a domestic partner, you must:

   - Have a serious, committed relationship with the Covered Person;
   - Be financially interdependent;
   - Not be related to the Covered Person in any way that would prohibit legal marriage by state law;

- Not be legally married to anyone else;
- Not be a domestic partner of anyone else; and
- Not be in a relationship that violates state or local laws.

3. Your natural blood related child, step-child, legally adopted child, a child for who you have a legal guardianship, or your child who is entitled to coverage under this Plan because of a medical child support order whose age is less than the limiting age. A dependent child is eligible for coverage:

    - Until the end of the month in which the child reaches the limiting age of 26; or
    - Until the end of the month in which the child reaches 28 only if all of the following are true:
        - The child is unmarried;
        - You request that your child be covered under the Plan;
        - The child is your natural child, stepchild, or adopted child;
        - The child is a resident of the Commonwealth of Kentucky or a full time student at an accredited public or private institution of higher education; and
        - The child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage.

4. Your child is incapable of self-sustaining employment by reason of developmental or intellectual disabilities or physical handicap and is primarily dependent upon you for support and maintenance.

Dependent Provisions

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

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

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

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

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

If you or your spouse is awarded legal custody or guardianship for a child, an application to add the child to your coverage must be submitted to the Marketplace or the Plan, as the case may be, within thirty-one (31) calendar days of the date of the filing of the petition for adoption or the filing of the application for appointment of guardianship. Coverage under the Plan will begin on the date of the filing of the petition for adoption or the filing of the application for appointment of guardianship.

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

The Plan will not deny enrollment to your child on the basis that the child was born out of wedlock; that the child is not claimed as a Dependent on your federal tax return; or that the child does not reside in your household or within the Plan's Service Area. If you are required by a court or administrative order to provide health care coverage for your Dependent child and you do not make application to obtain coverage for the child, the Plan will enroll your Dependent child as a Dependent under the Plan upon an application from the other parent or pursuant to a child support order and consistent with any applicable Marketplace or Plan rules or processes. The Plan will not terminate such child's coverage unless the Plan receives satisfactory written evidence that either the court or administrative order is no longer in effect or the child is or will be enrolled under comparable health care coverage provided by another health insurer, which coverage will take effect not later than the effective date of termination of this Plan. Please see Section 9: *Coordination of Benefits* for additional information.

Application and Enrollment for CareSource

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

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

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

Confirmation of Eligibility

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

If you are eligible for coverage under the Plan through direct enrollment with the Plan, then the Plan will confirm your eligibility in writing. The Plan will tell you the Premium that you must pay to enroll in the Plan as well as other important information about enrolling in the Plan.

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

Annual Eligibility Determinations

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

Enrollment Date

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

Ineligibility and Your Right to Appeal Certain Decisions

If you or your Dependent seek coverage through the Marketplace determines that you or your Dependent is not eligible for the Plan, the Marketplace will notify you. The Marketplace will give you information on other plans that may be available to you. It will explain how you can appeal any decision made by the Marketplace. You also have the right to appeal to the Marketplace if you disagree with the calculation of any subsidy amount. To appeal, you will need to request a hearing.

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

Availability of Benefits After Enrollment in the Plan

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

Change in Eligibility Status or Personal Information

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

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

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

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

Aside from these changes that must be disclosed to the Marketplace, the rate in effect on the date of issue or the date of your renewal is guaranteed with us for twelve (12) months. However, if this is your first year as a Covered Person under the Plan, and you enrolled in this Plan after January 1st, then your Benefit Year could be less than 12 months and the rate could change effective on your next renewal, which would be the following January 1st.

Open Enrollment

The Plan will hold open enrollment every year for those who are not enrolled in the Marketplace. If you are enrolled through the Marketplace, the Marketplace will give you information about the open enrollment process. If you are enrolled in the Plan through the Marketplace, you cannot choose another qualified health plan unless allowed by law. During the Marketplace open enrollment period following your initial enrollment in the Plan, you may choose another health plan for any reason.

Special Enrollment

A special enrollment period is a period during which a person who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, coverage through the Marketplace, outside of an annual open enrollment period. The length of a special enrollment period is sixty (60) calendar days from the date of a triggering event unless specifically stated otherwise. Special enrollment periods include the following:

1. Loss of health insurance coverage;

2. A new Dependent due to marriage, birth, adoption or placement for adoption;

3. Becoming a United States citizen;

4. Enrollment or non-enrollment in a Qualified Health Plan that was unintentional, inadvertent, or erroneous and is the result of an error of the Marketplace;

5. A Qualified Health Plan violates a material provision of its contract;

6. An individual is newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or a change in eligibility for cost-sharing reductions;

7. Existing employer coverage is no longer affordable to you or no longer provides the minimum value of coverage required by federal guidelines;

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

9. Release from incarceration.

SECTION 2 – HOW THE PLAN WORKS

This section includes information on:

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

Benefits

The Service Area

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

Out of Service Area Dependent Child Coverage

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

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

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

Network Providers

The Plan arranges for Providers to participate in its Network. Because of the importance of knowing whether Benefits are available to you when you use a Provider, you need to verify a Provider's status as a Network Provider by either calling Member Services at the toll-free telephone number on your ID Card or by logging onto our website. The Plan uses the CareSource Network, which has been approved by the Kentucky Department of Insurance.

Looking for a Network Provider?

The directory of our Network Providers is on our website at CareSource.com/marketplace. A printed directory may be provided to you free of charge.

Covered Services From Network Providers

The Plan provides Benefits when you receive Covered Services from Network Providers. You must choose the Network Providers to provide your Health Care Services.

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

Claims for Emergency Health Care Services and Covered Services provided by an Urgent Care Center outside the Service Area will be processed as if such services were rendered by a Network Provider. Such Benefits will be paid at the Network level and are limited to the Maximum Allowable Amount. Your payment is subject to any Coinsurance, Copayment, or Deductible. You may be responsible for any amount in excess of the Maximum Allowable Amount.

Services Provided by Non-Network Providers

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

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

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

If you receive Health Care Services from a Non-Network Provider and the Plan did not grant prior authorization for such Health Care Services, you are responsible for making full payment to the Non-Network Provider.

What You Must Pay

Premium Payments

Your monthly payments must be paid online at CareSource.com/marketplace or sent to the Plan at P.O. Box 12845, Covington, KY 41012-0845. The Plan will provide you with other important information on Premium payments. You can also find this information on our website. You will receive a monthly bill for your Premium. Your payment is due by the date stated on the bill. You must pay your Premium when it is due in order for your Benefits to continue. You will not receive Benefits for Covered Services if the Plan does not receive your Premium payments.

We reserve the right to change the Premium annually. You will receive sixty (60) calendar days' notice of any change in the amount of Premium, unless otherwise directed by law or the Marketplace.

If Premium has been paid for any period of time after coverage under the Plan is terminated, we will refund that Premium to you. The refund will be for the period of time after your coverage ends.

Grace Period

If at least one (1) full month's Premium has been paid during the Benefit Year, a Grace Period of three (3) consecutive months shall be granted for the payment of any Premium.

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

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

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

3. Deny all Prescription Drug Claims for Covered Services rendered to you in the second and third months of the Grace Period;

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

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

If you do not pay Premium for any period during the Benefit Year, any Health Care Services received during such period will not be covered by the Plan and the Grace Period provisions above will not apply to you. You are responsible for the costs of any Health Care Services that you receive for any period of time during the Benefit Year for which you did not pay Premium.

Your Provider(s) will bill you for such non-covered Health Care Services, and you will be responsible for directly paying your Provider(s).

Annual Deductible

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

Eligible Expenses

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

Coinsurance

Coinsurance is a fixed percentage of Eligible Expenses that you are responsible for paying for certain Covered Services after you meet the Annual Deductible.

Coinsurance - Example

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

Copayment

Copayment is the dollar amount that you are required to pay for certain Covered Services. For a complete definition of Copayment, see Section 13*: Glossary*.

Annual Out-of-Pocket Maximum

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

Plan Features	**Applies to the Annual Out-of-Pocket Maximum?**
Copayments	Yes
Payments toward the Annual Deductible	Yes
Coinsurance Payments	Yes

Plan Features	Applies to the Annual Out-of-Pocket Maximum?
Charges for Non-Covered Services	No

The Plan Does Not Pay for All Health Care Services

The Plan Benefits are limited to Covered Services. For a definition of Covered Services, see Section 12: *Glossary*. Not all Health Care Services will be covered by the Plan.

Your Primary Care Provider

Choose a PCP

CareSource allows you to choose a primary care Provider (PCP) who is a Network Provider. Your Network PCP will work with you to direct your health care. Your PCP will treat you for most of your routine health care needs. If needed, your PCP will send you to other doctors (specialists) or admit you to the Hospital. If you prefer, we will be happy to assist you in selecting your Network PCP. For information on how to select a PCP and for a list of Network PCPs, please contact Member Services or visit our website. If you do not select a PCP within thirty (30) calendar days after enrolling in the Plan, we may assign you to a PCP.

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

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

Visit Your PCP

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

Changing Your PCP

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

If You Can't Reach Your PCP

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

Canceling Provider Appointments

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

When You Need Specialty Care

If you think you need specialty care, we encourage you to first call your PCP. Your PCP can tell you whether you need specialty care and should refer you to an appropriate Network specialist. Before you visit a Network specialist, you should always check with your PCP or Network specialist to make sure that he or she has obtained any required prior authorization from the Plan.

Prior Authorization

Prior Authorization is the process used by the Plan to determine those Health Care Services listed on the Plan's Prior Authorization List that meet evidence based criteria for Medical Necessity and are Covered Services under your Plan prior to the Health Care Service being provided. Your Provider, whether a Network Provider or a Non-Network Provider, is responsible for obtaining prior authorization for the Health Care Services described on the Prior Authorization List. Please check with your Provider to ensure that your Provider has obtained prior authorization prior to you receiving any Health Care Services listed on the Prior Authorization List. The Prior Authorization List is available by calling Member Services at 1-888-815-6446 or by viewing it on our website at CareSource.com/marketplace. The Prior Authorization List is subject to change. Your Network Provider and you will be provided thirty (30) calendar days prior notice before a change is made to the Prior Authorization List.

If your Network Provider fails to obtain prior authorization from us for Health Care Services as required by us and such Provider renders such Health Care Services to you, the Network Provider shall be responsible for the costs of such Health Care Services and neither Plan nor you will be required to pay for such Health Care Services. If you receive Health Care Services from a Non-Network Provider and you or the Non-Network Provider did not obtain prior authorization

for such Health Care Services, you are responsible for making full payment to the Non-Network Provider.

Examples of types of Health Care Services that require Prior Authorization include:

- Non-Emergency Health Care Services provided by Non-Network Providers;
- Reconstructive procedures;
- Diagnostic Tests such as specialized labs, procedures and high technology imaging;
- Injectable drugs and medications;
- Inpatient Health Care Services;
- Specific surgical procedures;
- Nutritional supplements;
- Pain management services; and
- Transplant services.

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

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

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

Providers Who Leave the Network

If your PCP or a Provider who you see on a regular basis tells us that he or she is moving away, retiring, or leaving the Network for any reason, we will do our best to send you a written notice at least thirty (30) calendar days before your PCP or Provider who you see on a regular basis leaves the Network.

You can call us if you need help choosing another PCP. We may assign another PCP for you and send you the name of the PCP in writing. You can also call us if you need help choosing any other Provider who you may need to see on a regular basis.

Continuity of Care

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

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

Continuity of Care for Existing Covered Persons

We will continue to pay for Covered Services you receive from your PCP, for thirty (30) calendar days after the date your PCP leaves the Network unless your PCP was terminated from our Network for reasons related to Fraud or quality of care.

If you are undergoing treatment for Sickness, Injury, disability or a congenital condition, the Plan may authorize continuing coverage with that PCP from the date the PCP left the Network for up to ninety (90) calendar days. Your Provider should contact the Medical Management Department to obtain our prior authorization.

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

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

If you have a Terminal Illness, and the Provider you are seeing in connection with your Terminal Illness is no longer participating in the Plan (for reasons other than Fraud or quality of care), you may, with our prior authorization, continue to receive coverage for Covered Services provided

by that Provider until you no longer need Health Care Services. Please have your Provider contact the Medical Management Department to obtain our prior authorization.

Continuity of Care for New Covered Persons

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

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

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

2. Through your first postpartum visit, if you are a new Covered Person in your second or third trimester of Pregnancy.

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

You must obtain our prior authorization before continuing your care with a Non-Network Provider.

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

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

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

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

This section includes information on:

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

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

Emergency Health Care Services

Emergency Health Care Services are used to treat an Emergency Medical Condition. We provide Benefits for an Emergency Medical Condition within the United States, as such term is defined in Section 13: *Glossary*.

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

Remember, if you need Emergency Health Care Services:

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

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

Notice to Your PCP or the Plan Following Emergency Care

If you receive Emergency Health Care Services at an Emergency Room (whether inside or outside the Service Area), but are not admitted to the Hospital, you or someone acting on your behalf must call your PCP or the Plan within forty-eight (48) hours after receiving care. This will allow your PCP to provide or arrange for any follow-up care that you may need.

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

Transfer

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

Coverage for Urgent Care Services Outside the Service Area

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

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

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

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

Inpatient Hospital Stay

Inpatient Hospital Services

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

Charges After Your Discharge from a Hospital

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

How Benefits are Paid

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

SECTION 4 – YOUR COVERED SERVICES

This section includes information on:

- Your Covered Services; and
- When authorization is required.

This section provides an overview of your Covered Services. The Plan does not cover Health Care Services provided by Non-Network Providers except as specifically provided in Section 2: *Services Provided by Non-Network Providers;* Section 2: *How the Plan Works, Continuity of Care for New Covered Persons*; Section 3: *Coverage for Urgent Care Services Outside the Service Area* and *Inpatient Hospital Services;* and Section 4: *Your Covered Services, Emergency Health Care Services*. Please refer to Section 14: *Schedule of Benefits* for information related to the Annual Deductible, Coinsurance, Copayments and the Annual Out-of-Pocket Maximum.

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

1. AUTISM SPECTRUM DISORDER SERVICES – PSYCHIATRIC HEALTH CARE SERVICES FOR COVERED PERSONS REGARDLESS OF AGE

Description

The Plan provides Benefits for psychiatric Health Care Services used to treat Covered Persons with Autism Spectrum Disorders if such Health Care Services are:

- provided by or under the direction of an experienced Psychiatrist and/or an experienced licensed psychiatric Provider; and

- focused on treating maladaptive/stereotypic behaviors that are posing danger to the Covered Person, to others or to property, or that impair the Covered Person's daily functioning.

Benefits include the following services provided on either an Inpatient or Outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management. Benefits for Prescription Drugs are described in Section 5*: Prescription Drugs.*
- Individual, family, therapeutic group and Provider-based case management services.
- Crisis intervention.
- Direct or consultative Behavioral Health Care Services provided an individual licensed by the Kentucky Board of Examiners of Psychology or by the appropriate licensing agency in the state in which the individual practices.
- Direct or consultative psychiatric care services provided by a Psychiatrist licensed in the state in which the Psychiatrist practices.

Benefits include the following services provided on an Inpatient basis:

- Partial Hospitalization/day treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an Outpatient basis:

- Intensive Outpatient treatment.

For the purpose of this Benefit, "diagnostic evaluations and assessments" means Medically Necessary assessments, evaluations or tests to diagnose whether a Covered Person has any of the Autism Spectrum Disorders, including test tools which are appropriate to the presenting characteristics and age of the Covered Person and can be empirically validated for Autism Spectrum Disorders to provide evidence that meets the criteria for Autism Spectrum Disorder.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the Health Care Services have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as Applied Behavioral Analysis.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders for which Benefits are not subject to any age limit. Benefits for the non-psychiatric medical treatment of Autism Spectrum Disorders for enrolled Dependent children who are one (1) year through twenty-one (21) years of age are described in Section 4: *Your Covered Services – Autism Treatment for Covered Persons Under 21 Years of Age.* Benefits for those non-psychiatric Health Care Services used to treat Autism Spectrum Disorders for Covered Persons over the age of twenty-one (21) years of age s are available under the applicable medical Covered Health Care Services categories described in this EOC.

Coverage for Autism Spectrum Disorder will not be subject to dollar limits, deductibles, Copayments, or Coinsurance provisions that are less favorable than the dollar limits, deductibles, Copayments or Coinsurance provisions that apply to physical illness under the Plan.

Limitations

The following are not Covered Services:

1. Health Care Services for treatment of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

2. Any Health Care Services for Autism Spectrum Disorder that are not backed by credible research demonstrating that such Health Care Services have a measurable and beneficial health outcome and are considered as Experimental or Investigational or as Unproven Service.

3. Health Care Services when intellectual disability as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

4. School-based tuition or services for children and adolescents under the Individuals with Disabilities Education Act.

5. Health Care Services for 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.

6. Health Care Services for the primary diagnosis of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.

7. Intensive behavioral therapies such as Applied Behavioral Analysis for Autism Spectrum Disorder for Covered Persons age twenty-two (22) years of age or older.

8. Health Care Services for the diagnosis or treatment of a Behavioral Health Disorder which are:

    a. Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
    b. Not supported by credible research that soundly demonstrates that such Health Care Services will have a measurable and beneficial health outcome, and therefore considered Experimental or Investigational.
    c. Not consistent with the current level of care guidelines or best practices as may be modified from time to time.

d. Not clinically appropriate for the patient's Behavioral Health Disorder or condition based on generally accepted standards of medical practice and benchmarks.

2. AUTISM TREATMENT FOR COVERED PERSONS UNDER THE AGE OF 21 YEARS

Description

The Plan provides Benefits for the treatment of Autism Spectrum Disorders for Covered Persons who are one (1) year of age through twenty-one (21) years of age.

This section describes only the medical component of treatment for Autism Spectrum Disorders for enrolled Dependent children one (1) year of age through twenty-one (21) years of age. Psychiatric Health Care Services for the treatment of Autism Spectrum Disorders (including diagnostic evaluation and assessment services, Habiliitative Services and rehabilitative care which includes professional counseling and guidance services, therapy and treatment programs including behavior therapy and psychological care) are Covered Health Care Services for which Benefits are available as described under Section 4: *Your Covered Services – Autism Spectrum Disorder for Covered Persons Regardless of Age.*

For the purpose of this Benefit, "treatment of Autism Spectrum Disorders" means:

- Medical care.
- Pharmacy Drugs for which Benefits are described in Section 5: *Prescription Drugs.*
- Therapeutic care which includes speech therapy, occupational therapy and physical therapy. Please see Section 4: *Your Covered Services – Therapy Services* for more information on this Benefit.

Please note that the medical treatment of Autism Spectrum Disorders for all other Covered Persons is a Covered Service for which Benefits are available under the applicable medical Covered Services categories under the Plan.

3. AMBULANCE SERVICES

Description

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

The Plan provides Benefits for Emergency Ambulance Services to the nearest Hospital where Emergency Health Care Services can be provided.

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

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

The Plan also provides Benefits for Emergency Health Care Services provided by Emergency medical responders at your home or at the scene of an accident, or during transportation by Ambulance Services if you are subsequently transported to a Facility.

Authorization Requirements

Authorization of Ambulance Services for non-Emergencies are subject to prior authorization. Always check with your Provider to make sure he or she has obtained the necessary prior authorization.

Prior authorization is not required for Ambulance Services related to the provision of Emergency Health Care Services

Limitations

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

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

4. BEHAVIORAL HEALTH CARE SERVICES

Description

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

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

that your Network Provider has obtained prior authorization from us before receiving such services.

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

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

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

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

Authorization Requirements

Your Provider must obtain prior authorization from us for all Inpatient Stays, Residential Treatment Programs, Partial Hospitalization programs, and Intensive Outpatient Services related to Behavioral Health Care Services. Please confirm that your Provider has obtained prior authorization from us before receiving such services.

Limitations

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

The following Health Care Services are not Covered Services:

- Custodial Care or Domiciliary Care.
- Supervised living or halfway houses.

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

5. COVERED CLINICAL TRIALS

Description

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

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

- The United States Department of Defense; or
- The United States Department of Veteran's Affairs.

Limitations

The Plan does not cover the following:

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

Authorization Requirements

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

6. DENTAL SERVICES – PEDIATRIC

Description

The Plan provides pediatric dental Benefits for children up to the end of the month in which a child turns twenty-one (21) years of age. Please see Section 15: *Dental & Vision Services – Pediatric* for more information on this Benefit.

7. DENTAL SERVICES - RELATED TO ACCIDENTAL INJURY

Description

The Plan provides Benefits for Outpatient Services, Physician Home Visits and Office Services, Emergency Health Care Services and Urgent Care Services for dental work and oral surgery if they are for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting your condition. "Initial"

dental work to repair injuries due to an accident means performed within twelve (12) months from the Injury, or as clinically appropriate and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to a dental related Injury, the Plan may provide Benefits, in its discretion, even if there may be several years between the accidental Injury and the final repair.

Covered Services for dental services related to accidental Injury include:

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

Other Dental Services

Benefits are provided for anesthesia and Hospital or Facility charges for services performed in a Hospital and Ambulatory Surgical Facility. These services must be in connection with dental procedures for Members below the age of nine years, Members with serious mental or physical conditions, and Members with significant behavioral problems. Also, the admitting Physician or dentist must certify that, because of the patient's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures. Benefits are not provided for routine dental care.

If the above paragraph does not apply to a Member, the only other dental expenses that are Covered Services are Facility charges for Outpatient services for the removal of teeth or for other dental processes. Benefits are payable only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

Limitations

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

8. DIABETIC EDUCATION, EQUIPMENT, AND SUPPLIES

Description

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

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

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

Limitations

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

9. DIAGNOSTIC SERVICES

Description

The Plan provides Benefits for non-invasive Diagnostic Services, including the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease;
- Laboratory and pathology services;
- Advanced Imaging such as: MRI, MRA, PET, SPECT and CT imaging procedures;
- Allergy testing;
- Bone density testing; and
- Cardiographic, encephalographic, and radioisotope tests.

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

Authorization Requirements

Coverage for certain Diagnostic Services may be subject to prior authorization. Please review the Prior Authorization List for further detail. You should always check with your Provider to make sure he or she has obtained necessary prior authorization.

10. EMERGENCY HEALTH CARE SERVICES

Description

The Plan provides Benefits for Emergency Health Care Services (Please refer to Section 3: *Important Information on Emergency, Urgent Care, Inpatient, and Maternity Services*). Health Care Services which we determine to meet the definition of Emergency Health Care Services will be Covered Services, whether the care is rendered by a Network Provider or a Non-Network Provider. The Plan provides Benefits for treatment of an Emergency Medical Condition, the Emergency Medical Condition screening and the services to Stabilize an Emergency Medical Condition without prior authorization for conditions that reasonably appear to constitute an Emergency Medical Condition based upon your presenting symptoms and conditions. Benefits for Emergency Health Care Services include Facility costs and Physician services, and supplies and Prescription Drugs charged by that Facility.

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

Limitations

Benefits provided under this section are payable at the Network level and are limited to the Maximum Allowable Amount. The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of:

- The amount negotiated with Network Providers for the Emergency service furnished;
- The amount for the Emergency Service calculated using the same method we use to determine payments for Non-Network services but substituting the Network cost-sharing provisions for the Non-Network cost-sharing provisions; or
- The amount that would be paid under Medicare for the Emergency Service.

Your payment is subject to any Coinsurance, Copayment, or Deductible. You may be responsible for any amount in excess of the Maximum Allowable Amount.

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

11. ENDOMETRIOSIS AND ENDOMETRITIS

Covered Services include coverage for diagnosis and treatment of endometriosis and endometritis.

12. FAMILY PLANNING SERVICES

Description

The Plan covers Benefits for Family Planning Services that include:

- Birth control and contraceptive devices (including condoms);
- Sexually transmitted infections tests and treatment;
- Screenings for cervical cancer and/or mammograms (when indicated by a breast examination during a routine or periodic family planning visit), as further described in this EOC;
- Immunization vaccines for children from birth to age 18. (Doses, recommended ages, and recommended populations will vary.)

Family Planning Services are Covered Services under the Preventative Health Service Benefit. Please refer to Section 4: *Your Covered Services – Preventive Health Care Services* for additional information.

13. HABILITATIVE SERVICES

Description

The Plan provides Benefits for Habilitative Services.

Benefits are provided for Habilitative Services provided on an Outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed Social Worker or licensed Psychologist; and

- The initial or continued treatment must not be Experimental or Investigational or an Unproven Service.

Benefits for Habilitative Services do not apply to those Health Care Services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not Habilitative Services. A Health Service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a Habilitative Service. When the Covered Person reaches his/her maximum level of improvement or does not

demonstrate continued progress under a treatment plan, a Health Service that was previously a Habilitative Service will no longer be considered by the Plan to be a Habilitative Service.

We may require that a treatment plan, medical records, clinical notes, or other necessary data be provided to us in order for us to substantiate that the Health Care Services are Medically Necessary and that the Covered Person's condition is clinically improving as a result of the Habilitative Service. When the treating Provider anticipates that continued Health Care Services are or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of the diagnosis, the proposed treatment by type, the frequency, the anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this Benefit, the following definitions apply:

- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Limitations

Other than as described above, the Plan provides Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders. The Pan provides Benefits for Cognitive Rehabilitation Therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Please see Section 4: *Your Covered Services – Therapy Services* for more information on therapy service Benefits such as physical therapy, occupational therapy, and speech therapy.

14. HEARING AIDS AND RELATED SERVICES

The Plan covers hearing aids and related services for Covered Persons as follows: One (1) hearing aid per hearing impaired ear every thirty-six (36) months.

15. HOME HEALTH CARE SERVICES

Description

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

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).

- Medical/Social Services.
- Diagnostic Services.
- Nutritional guidance.
- Home Health Care Agency aide services furnished by appropriately trained personnel employed by the Home Health Care Agency if you are receiving skilled nursing or therapy. Organizations other than Home Health Care Agencies may provide services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Agency.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in Section 14: *Schedule of Benefits* for Home Health Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).
- Private Duty Nursing.

Limitations

The Plan provides Benefits for up to a maximum of one hundred (100) combined Home Health Care Services visits per Benefit Year. Each visit by an authorized representative of a Home Health Care Agency shall be considered as one (1) Home Health Care visit, except that at least four (4) hours of home health aide services shall be considered as one (1) Home Health Care visit. Benefits for Private Duty Nursing are limited to two-hundred fifty (250) eight (8) hour visits per Benefit Year.

Non-Covered Services include:

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

16. **HOME INFUSION THERAPY**

Description

The Plan provides Benefits for Home Infusion Therapy. Benefits for Home Infusion Therapy include nursing, Durable Medical Equipment and pharmaceutical services that are delivered and administered intravenously in the home. Home IV therapy includes: injections, total parenteral nutrition, enteral nutrition therapy, antibiotic therapy, pain management and chemotherapy.

Authorization Requirements

Your Provider must obtain our prior authorization prior to you receiving Home Infusion Therapy Provider services. Please confirm that your Provider has obtained prior authorization from us before receiving such services.

17. **HOSPICE SERVICES**

Description

The Plan provides Benefits for Hospice services if you have a Terminal Illness for up to six (6) months. Hospice care may be provided in your home or at a Hospice Facility where medical, social and psychological services are given to help treat individuals with Terminal Illnesses. Hospice services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice Benefits, you must have a Terminal Illness. When recommended by your attending Physician, Hospice Benefits may be provided beyond the six (6) month limit. Our payment will be no less than Medicare for this Benefit. Benefits for Hospice Services will not be subject to your Deductible unless this Plan is a high deductible health plan.

Hospice services that qualify as Covered Services include the following:

- Skilled Nursing Services (by an R.N. or L.P.N.).
- Diagnostic Services.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances.
- Counseling services.
- Inpatient Stay at a Hospice Facility.
- Prescription Drugs given by the Hospice.
- Home health aide services.

Limitations

Non-Covered Services include:

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

18. INFERTILITY SERVICES

Description

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

Limitations

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

19. INPATIENT SERVICES

Description

The Plan provides Benefits for Inpatient Services, including:

- Charges from a Hospital or Skilled Nursing Facility (SNF) or other Provider as authorized by the Plan for room, board and general nursing services, as follows:
  - A room with two (2) or more beds.
  - A private room. The private room allowance is the Hospital's average Semi-private Room rate unless it is Medically Necessary that you use a private room for isolation and no isolation Facilities are available.
  - A room in a special care unit approved by us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.
- Ancillary (related) services, as follows:
  - Charges for operating, delivery and treatment rooms and equipment.
  - Prescription Drugs.
  - Anesthesia, anesthesia supplies and services.
  - Medical and surgical dressings, supplies, casts and splints.
  - Diagnostic Services.
  - Therapy Services.

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

When you are transferred from one Hospital or Facility to another Hospital or Facility on the same day, any Copayment per admission in Section 14: *Schedule of Benefits* is waived for the second admission.

Authorization Requirements

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

Limitations

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

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

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

20. **MATERNITY SERVICES**

Description

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

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

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

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

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

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

The Plan also provides Benefits for at-home post-delivery care visits by your Physician or Nurse performed no later than seventy-two (72) hours following you and your newborn child's discharge from the Hospital. Covered Services for at-home post-delivery care visits include:

- parent education;
- assistance and training in breast or bottle feeding; and

- performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

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

21. MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND APPLIANCES

Description

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

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

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

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

- The equipment, supply or appliance is worn out or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- Your needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
- The equipment, supply or appliance is damaged and cannot be repaired.

The Plan provides Benefits for:

- Medical and surgical supplies - Certain supplies and equipment for the management of disease that we approve will be Covered Services as Prescription Drug Services. These supplies are considered as a medical supply Benefit if you do not receive the supplies, equipment or appliances from our Pharmacy Benefit Manager's mail service or from a Network Pharmacy.
- Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose
- Allergy serum extracts
- Chem strips, Glucometer, Lancets

- Clinitest
- Ostomy bags and supplies provided; however, the Plan does not provide Benefit Health Care Services related to the fitting of such Ostomy bag and supplies.
- Therapeutic food, formulas, supplements, and low-protein modified food products for the treatment of inborn errors of metabolism or genetic conditions if the therapeutic food, formulas, supplements, and low-protein modified food products are obtained for the therapeutic treatment of inborn errors of metabolism or genetic conditions under the direction of a Physician. Benefits available for their use are limited to conditions required by law. Prior Authorization is required.
- 100% human diet, if the 100% human diet and supplemented milk fortifier products are prescribed for the prevention of necrotizing enterocolitis and associated co-morbidities and administered under the direction of a physician. 100% human diet means the supplementation of a mother's expressed breast milk or donor milk with a milk fortifier. Prior authorization is required.
- Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.

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

Authorization Requirements

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

Limitations

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

The following items are not Covered Services:

- Adhesive tape, Band-Aids, cotton tipped applicators
- Arch Supports
- Doughnut cushions
- Hot packs, ice bags
- Vitamins
- Medinjectors

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

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

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

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

Limitations

The following are not Covered Services:

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

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

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

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

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

Covered Services for prosthetics include:

- Aids and supports for defective parts of the body including internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
- Breast prosthesis whether internal or external, following a mastectomy, and four (4) surgical bras per Benefit Year, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
- Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or eyeglasses prescribed following lens implantation are Covered Services. If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session. Eyeglasses (for example bifocals) including frames or contact lenses are Covered Services when they replace the function of the human lens for conditions caused by cataract surgery or aphakia. The first pair of contact lenses or eyeglasses following surgery are covered. The donor lenses inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the Injury is to one eye or if cataracts are removed from only one eye and you select eyeglasses and frames, reimbursement for both lenses and frames will be covered.
- Cochlear implant.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis)

- Wigs (the first one following cancer treatment, not to exceed one (1) per Benefit Year).

Limitations

The following are not Covered Services:

- Denture, replacing teeth or structures directly supporting teeth
- Dental appliances when the primary diagnosis is dental in origin. This exclusion does not apply to dental appliances for which Benefits are provided as described under Section 15 – *Dental & Vision Services – Pediatric.*
- Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets
- Artificial heart implants
- Penile prosthesis in men suffering from impotency resulting from disease or Injury.

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

The Plan provides Benefits for certain orthotic devices. The Plan provides Benefits for the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

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

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

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

Limitations

The following are not Covered Services:

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

Benefits for repairs and replacement do not include the following:

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

22. OUTPATIENT SERVICES

Description

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

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

Limitations

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

23. PHYSICIAN HOME VISIT AND OFFICE SERVICES

Description

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

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

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

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

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

Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

Limitations

Non-Covered Services include communications used for:

- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage or payment questions;
- Requests for referrals to doctors outside the online care panel;
- Benefit precertification; and
- Physician to Physician consultation

24. PHYSICAL MEDICINE AND REHABILITATION SERVICES

Description

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

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

The Plan provides Benefits for Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those individuals who do not require Inpatient care but still require a

rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day Rehabilitation Program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuro-psychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

Limitations

Non-Covered Services for physical medicine and rehabilitation include admissions to a Hospital mainly for physical therapy.

25. PRESCRIPTION DRUGS

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

26. PREVENTIVE HEALTH CARE SERVICES

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

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

- Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
  - Breast cancer (mammogram);
  - Cervical cancer;
  - Colorectal cancer (colonoscopy);
  - High Blood Pressure;
  - Type 2 Diabetes Mellitus;
  - Cholesterol; and
  - Child and Adult Obesity.
- Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive Health Care Services for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional Preventive Health Care Services for women provided for in the guidelines supported by the Health Resources and Services Administration, including

contraceptives, breast feeding support, and female sterilization procedures and related services when received in a Physician's office or on an Outpatient basis at a Hospital or Alternate Facility. Female sterilization benefits include the Facility charge, the charge for required Hospital-based professional services, supplies and equipment, and for the surgeon's fee.

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

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

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

- Routine cytologic screening for the presence of cervical cancer and chlamydia screening (including pap test).
- Routine screening mammograms including coverage for low-dose mammography screening.
- Routine colorectal cancer examination and related laboratory tests.
- Child health supervision services from the moment of birth until age nine (9). Child health supervision services mean periodic review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, or, in the case of hearing screening, by an individual acting in accordance with Kentucky law. Periodic review means a review performed in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.
- Routine hearing screenings.
- Routine visions screenings and examinations.
- Sports physicals for children who are in elementary school through high school.

27. RECONSTRUCTIVE SERVICES

Description

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

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

Authorization Requirements

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

28. STERILIZATION

Description

The Plan provides Benefits for male surgical sterilization procedures and related services received in a Physician's office or on an Outpatient basis at a Hospital or Alternate Facility.

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

29. SURGICAL SERVICES

Description

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

- Performance of accepted operative and other invasive procedures, including:
  - Operative and cutting procedures;

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

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

Authorization Requirements

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

30. TELEHEALTH CARE SERVICES

Covered Services include a medical or health consultation for purposes of patient diagnosis or treatment, that requires the use of advanced telecommunications technology, including, but not limited to:

- Compressed digital interactive video, audio, or data transmission;
- Clinical data transmission via computer imaging for teleradiology or telepathology; and
- Other technology that facilitates access to other covered Health Care Services or medical specialty expertise.

31. TEMPOROMANDIBULAR OR CRANIOMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR JAW DISORDER

Description

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

Authorization Requirements

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

32. THERAPY SERVICES

Description

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

Physical Medicine Therapy Services

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

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

Occupational Therapy Services

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

Speech Therapy

The Plan will provide Benefits for speech therapy for a correction of a speech impairment.

Manipulation Therapy

The Plan will provide Benefits for manipulation therapy that includes osteopathic/chiropractic manipulation therapy used for treating problems associated with bones, joints and the back. The two (2) therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for manipulation therapy services as specified in Section 14: *Schedule of Benefits*.

Other Therapy Services

The Plan will provide Benefits for therapy services for:

- Cardiac rehabilitation to restore your functional status after a cardiac event. Cardiac rehabilitation services includes a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- Pulmonary rehabilitation to restore an individual's functional status after a Sickness or Injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling.

Limitations

The following visit limitations apply to each therapy service. Prior Authorization is required for visits in excess of these limits.

- Physical Therapy: Twenty-five (25) visits per Benefit Year when rendered as Physician Home Visits and Office Services or Outpatient Services. When rendered in the home, Home Health Care Services limits apply.

  NOTE: Covered Persons may receive twenty-five (25) physical therapy visits per Benefit Year for rehabilitation purposes in accordance with Section 4: *Your Covered Services, Physical Medicine and Rehabilitation Services* and may receive twenty-five (25) physical therapy visits per Benefit Year for Habilitative purposes in accordance with Section 4: *Your Covered Services, Habilitative Services.*

Limitation

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

- Occupational Therapy: Twenty-five (25) visits per Benefit year when rendered as Physician Home Visits and Office Services or Outpatient Services. When rendered in the home, Home Health Care Services limits apply.

NOTE: Covered Persons may receive twenty-five (25) occupational therapy visits per Benefit Year for rehabilitation purposes in accordance with Section 4: *Your Covered Services, Physical Medicine and Rehabilitation Services* and may receive twenty-five (25) occupational therapy visits per Benefit Year for Habilitative purposes in accordance with Section 4: *Your Covered Services, Habilitative Services.*

Limitation

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

- Speech Therapy: The Plan provides Benefits for up to twenty-five (25) visits per Benefit Year when rendered as Physician Home Visits and Office Services or Outpatient Services. When rendered in the home, Home Health Care Services limits apply.
  NOTE: Covered Persons may receive twenty-five (25) speech therapy visits per Benefit Year for rehabilitation purposes in accordance with Section 4: *Your Covered Services, Physical Medicine and Rehabilitation Services* and may receive twenty-five (25) speech therapy visits per Benefit Year for Habilitative purposes in accordance with Section 4: *Your Covered Services, Habilitative Services.*

- Manipulation Therapy: Twenty (20) visits per Benefit Year.

- Post-Cochlear Implant Aural Therapy: Thirty (30) visits per Benefit Year.

- Cognitive Rehabilitation Therapy: Twenty (20) visits per Benefit Year.

Limitation

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

- Cardiac Rehabilitation: Thirty-six (36) visits per Benefit Year when rendered as Physician Home Visits and Office Services or Outpatient Services. When rendered in the home, Home Health Care Services limits apply.
- Pulmonary Rehabilitation: Twenty-five (25) visits when rendered as Physician Home Visits and Office Services or Outpatient Services. When rendered in the home, health Care Services limits apply. When rendered as part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.

Other Services

- Chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- Dialysis treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
- Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes. Radiation therapy includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; and treatment planning.
- Inhalation Therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics of inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

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

Description

Covered Transplant Procedure

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

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

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

The Transplant Benefits outlined below do not apply to any Covered Services related to a Covered Transplant Procedure that are received prior to or after the Transplant Benefit Year. Please note that the initial evaluation and any necessary additional testing to determine your

eligibility as a candidate for transplant by your Provider and storage of bone marrow/stem cells is included in the Covered Transplant Procedure Benefit regardless of the date of service.

Transplant Benefit Year

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

Transportation and Lodging

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

Authorization Requirements

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

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

Limitations

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

Non-Covered Services for transportation and lodging include:

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

34. URGENT CARE SERVICES

Description

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

Benefits are also available for Urgent Care Services received at a Non-Network Urgent Care Center.

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

35. **VISION SERVICES – PEDIATRIC**

Description

The Plan provides pediatric vision Benefits for children to supplement the routine eye examinations and refractions under this EOC for children up to the end of the month in which a child turns twenty-one (21) years of age. Please see Section 15: *Dental & Vision Services – Pediatric* for more information on this Benefit.

SECTION 5 – PRESCRIPTION DRUGS

What this section includes:

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

How Prescription Drug Coverage Works

This section provides an overview of the Plan's Prescription Drug coverage. See Section 14: *Schedule of Benefits* for Copayment amounts that apply when you have a prescription filled at a Network Pharmacy. If you have any questions about the Plan's Prescription Drug coverage, you may call the Pharmacy phone number listed on your ID Card.

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

Pharmacy Benefits Manager

The Pharmacy Benefits available to you under this EOC are administered by our PBM. The management and other services the PBM provides include, among others, making recommendations to, and updating, the covered Prescription Drug List and managing a network of retail pharmacies and, operating a Mail Service Pharmacy, and a Specialty Drug Pharmacy Network. The PBM, in consultation with us, also provides services to promote and enforce the appropriate use of Pharmacy Benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/Pregnancy concerns.

Our covered Prescription Drug List is available online. The CareSource website includes a formulary lookup tool from which you can search for a particular drug or you may also call the Member Services. The covered Prescription Drug List is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug List is not a guarantee of coverage.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary in order to be Covered Services. Prescription Drugs will be covered for FDA approved indications. Prescription drugs will also be covered for off label and Experimental or Investigational uses provided that the drug has been recognized as safe and effective for the treatment of your condition in one or more of the standard medical references adopted by the United States Department of Health and Human Services under 42 U.S.C. 1395x(t)(2). For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the Plan can determine Medical Necessity. The Plan will establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer. Covered Services will be

limited based on Medical Necessity, quantity and/or age limits established by the Plan, or utilization guidelines.

Prior authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug Benefit coverage. At the time you fill a prescription, the Network pharmacist is informed of the prior authorization requirement through the Pharmacy's computer system. CareSource uses pre-approved criteria, developed by our Pharmacy and Therapeutics Committee, which is reviewed and adopted by us. We may contact your Provider if additional information is required to determine whether prior authorization should be granted. We communicate the results of the decision to both you and your Provider.

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

For a list of the current drugs requiring prior authorization, please review our Pharmacy list or use our online formulary look-up tool, both available on our website or contact Member Services. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a drug or related item on the covered Prescription Drug list is not a guarantee of coverage under your EOC. Your Provider or Network Pharmacist may check with us to verify covered Prescription Drugs, any quantity and/or age limits, or applicable Brand-name Drugs or Generic Drugs recognized under the Plan.

Benefit Levels

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

Tiers

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

- Tier 0: Prescription Drugs include preventive medications. These medications are available without a Copayment or Coinsurance.
- Tier 1: Prescription Drugs in this tier contain low cost Generic Drugs.
- Tier 2: Prescription Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier will contain preferred medications that may be single or multi source Brand-name Drugs.
- Tier 3: Prescription Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier will contain non-preferred medications. This will include medications considered single- or multi-source Brand-name Drugs.
- Tier 4: Prescription Drugs have a higher Coinsurance or Copayment than those in Tier 3. Medications generally classified as specialty preferred medications fall into this category.

- Tier 5: Prescription Drugs have a higher Coinsurance than those in Tier 4. Medications generally classified as specialty non-preferred medications fall into this category.

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

- The applicable Copayment;
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- The Prescription Drug Cost that the Plan agreed to pay the Network Pharmacy.

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

- The applicable Copayment; or
- The Prescription Drug Cost for that particular Prescription Drug.

If there is a Generic Drug available for a Brand-name Drug, the preference is that you receive the Generic Drug. If you elect to take the Brand-name Drug when a Generic Drug is available, then you will have to pay the difference between the cost of the Brand-name Drug and the Generic Drug.

Patient-administered anticancer medications that are considered Covered Services will not require a higher Copayment, Coinsurance, or Deductible than health care provider-administered anticancer medications that are considered Covered Services. Anticancer medications are drugs and biologics that are used to kill, slow, or prevent the growth of cancerous cells.

How to Obtain Prescription Drug Benefits

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

Network Pharmacy

Present your written Prescription Order from your Physician, and your ID Card to the Pharmacist at a Network Pharmacy. The Pharmacy will file your Claim for you.

You will be charged at the point of purchase for applicable Copayment or Coinsurance amounts. If you do not present your ID Card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your Pharmacist for an itemized receipt. You will have to complete a form and return it to our PBM for reimbursement.

Specialty Drugs

You or your Physician must order your specialty drugs directly from your PBM's specialty Pharmacy by calling Member Services. There are certain medications that are more complex for diseases that require special attention and need to be handled differently than medications you pick up at your local Pharmacy. These medications are called specialty medications, and most of these medications require a prior authorization from your Physician. Many of these medications

need to be given to you by a Physician or nurse, and your Physician's office will help you get that done. If the prior authorization is approved, we will work with your doctor's office and the specialty Pharmacy.

Non-Network Pharmacy

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

The Mail Service Program

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

You are not required to use the Mail Service Program.

Special Programs

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

Half-Tablet Program

The Half-Tablet Program allows you to pay a reduced Copayment on selected medications. The Half-Tablet Program allows you to obtain a thirty (30) day supply of the higher strength medication when written by the Physician to take those medications on the approved list. Our Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list of medications. The Half-Tablet Program is strictly voluntary and your decision to participate should follow consultation with and the agreement of your Physician.

Therapeutic Substitution of Drugs Program

Therapeutic Substitution of Drugs is a program designed to increase Generic Drug use, which in turn lowers your medication costs.

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

Step Therapy

Step therapy means that you may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control use, to ensure that appropriate prescribing

guidelines are followed, and to help you access high quality, yet cost effective, Prescription Drugs. If your Physician decides that the medication is needed, the prior authorization process may be required.

Designated Pharmacy

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

Assigning Prescription Drugs to Tiers

CareSource's Pharmacy and Therapeutics Committee makes the final approval of Prescription Drug placement in tiers. In its evaluation of each Prescription Drug, the Pharmacy and Therapeutics Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- Evaluations of the place in therapy;
- Relative safety and efficacy; and
- Whether supply limits or notification requirements should apply.

Economic factors may include:

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

When considering a Prescription Drug for tier placement, the Pharmacy and Therapeutics Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug is appropriate for an individual Covered Person is a decision that is made by the Covered Person and the prescribing Physician.

The Pharmacy and Therapeutics Committee may periodically change the placement of a Prescription Drug among the tiers. These changes will not occur more than six (6) times per Benefit Year and may occur without prior notice to you.

Notification Requirements

Before you can get certain Prescriptions, your Physician, your Pharmacist, or you must notify CareSource. CareSource will determine if the Prescription Drug is:

- A Covered Service as defined by the Plan; and
- Not Experimental or Investigational or an Unproven Service, as defined in Section 13: *Glossary*.
- To determine if a Prescription Drug requires notification, either visit our website or call the toll-free number on your ID Card. From time to time, CareSource may change the Prescription Drugs requiring notification.

Network Pharmacy Notification

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing Provider, the Pharmacist, or you are responsible for notifying the PBM.

If CareSource is not notified before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. If CareSource is not notified before you purchase the Prescription Drug, you can request a refund after you receive the Prescription Drug.

When you submit a Claim on this basis, you may pay more because you did not notify the PBM before the Prescription Drug was dispensed. The amount you are refunded will be based on the Prescription Drug Cost (less the required Copayment and/or Coinsurance and any deductible that applies).

Benefits may not be available for the Prescription Drug after the PBM reviews the documentation provided and determines that the Prescription Drug is not a Covered Service or it is an Experimental or Investigational or Unproven Service.

Limitation on Selection of Pharmacies

If the PBM determines that you may use Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future Pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within thirty (30) calendar days of the date the Plan Administrator notifies you, the Pharmacy Benefit Manager will select a single Network Pharmacy for you.

Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit our website or call Member Services. If you need a refill before your supply is gone, call Member Services. CareSource may change the supply limit of a Prescription Drug at any time.

If you have been prescribed eye drops and your prescription states that refills are needed, you may obtain refills as follows:

A. If your prescription calls for a 30-day supply, you may obtain a refill between 25-30 days from the later of: (i) the original date you received the prescription or (ii) the date of your most recent refill;

B. If your prescription calls for a 90-day supply, you may obtain a refill between 80-90 days from the later of: (i) the original date you received the prescription or (ii) the date of your most recent refill.

C. You are also permitted one (1) additional bottle of prescription eye drops if your prescription states than an additional bottle is needed for use in a day care center or school.

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

If a Brand-name Drug becomes available as a Generic Drug, the tier placement of the Brand-name Drug may change. As a result, your Copayment may change. You will pay the Copayment applicable for the tier to which the Prescription Drug is assigned. If you or your Physician want to continue using the same Brand-name Drug when a Generic Drug is available, the Brand-name Drug Copayment will be applied. The cost of the Brand-name Drug Copayment may be higher than that of the Generic Drug Tier Copayment.

Covered Prescription Drug Benefits

- Prescription Drugs from our Prescription Drug List
- Injectable insulin and syringes used for administration of insulin
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma) are covered without any Copayment/Coinsurance. Contact us to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Mail Service or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.

Exclusions - What the Prescription Drug Plan Will Not Cover

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

Medications that are:

- For any condition, Injury, Sickness or Behavioral Health Disorder arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a Claim for such benefits is made or payment or benefits are received;
- A Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
- Pharmaceutical products for which Benefits are provided under the medical portion of this EOC (Section 4: *Your Covered Services*);
- An available over-the-counter drug that does not require a prescription order or refill by federal or state law before being dispensed, unless the Plan has designated the over-the-counter drug as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician;
- Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent;

- Certain Prescription Drugs that the Plan has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six (6) times during a Benefit Year, and the Plan may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision;
- Compounded drugs that do not contain at least one ingredient that has been approved by the United States Food and Drug Administration and requires a prescription order or refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3);
- Dispensed by a Pharmacy that is a Non-Network Provider;
- Dispensed outside of the United States;
- Durable Medical Equipment (prescribed and non-prescribed Outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);
- Dispensed in an amount (days' supply or quantity limit) which exceeds the supply limit;
- Prescribed, dispensed, or intended for use during an Inpatient Stay;
- Prescribed for appetite suppression and other weight loss products;
- 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 are Therapeutically Equivalent to another covered Prescription Drug;
- Typically administered by a qualified Provider or licensed health professional in an Outpatient setting. This Exclusion does not apply to Depo Provera and other injectable drugs used for contraception;
- Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless CareSource has agreed to cover an Experimental or Investigational or Unproven Service, as defined in Section 13: *Glossary*;
- Used for Cosmetic Procedures or purposes;
- For growth hormone therapy to treat familial short stature. (This Exclusion does not apply to growth hormone therapy which is Medically Necessary, as determined by CareSource, to treat a diagnosed medical condition other than familial short stature);
- Used for treatment of onchomycosis; and
- Fertility drugs unless used to treat the medical condition that results in infertility.

Prescription Drug Exception Process

The Plan has in place an exception process that allows you to request Benefits for Prescription Drugs that are not covered by the Plan. The exception process is described below, and it only applies to Prescription Drugs. This process is distinct from the appeal process described in Section 8: *Complaint Process, Claims Procedures and Adverse Benefit Determination Appeals*

and does not limit your rights under Section 8: *Complaint Process, Claims Procedures and Adverse Benefit Determination Appeals* to the extent that the processes are not duplicative.

Step 1 – Internal Review

If the Plan denies Benefits for a Prescription Drug, you must request that the Plan consider an exception either verbally or in writing within sixty (60) calendar days following the date of Plan's notification of the denial. With your consent, such request may also be submitted on your behalf by your Authorized Representative or by the Provider who prescribed such Prescription Drug. The Plan shall provide you with verbal notification of its determination as expeditiously as your health condition requires but will use its best efforts to provide you with verbal notification of its decision within seventy-two (72) hours after your request was received by the Plan. If you are suffering from a serious health condition, the Plan will use its best efforts to provide you with verbal notification of its determination with twenty-four (24) hours after your request was received. The Plan will also issue its decision in writing no later than forty-eight (48) hours after the Plan provided you with verbal notice of its decision. If your request is denied, such written notification will explain how you may request an independent review of the Plan's internal review determination.

Step 2 – Independent Review

If the Plan denies your request for an exception in the Step 1- Internal Review process described above, you may request either verbally or in writing that independent review of the Plan's determination be conducted. With your consent, such request may also be submitted on your behalf by your Authorized Representative or by the Provider who prescribed such Prescription Drug. Such request must be received by the Plan within sixty (60) calendar days of the date of the Plan's written internal review decision. The independent review will be conducted by an independent review entity contracted by the Plan to review the exception request denial. The independent review entity shall provide you with verbal notification of its determination as expeditiously as your health condition requires but will use its best efforts to provide you with verbal notification of its decision within seventy-two (72) hours after your request was received by the independent review entity. If you are suffering from a serious health condition, the independent review entity will use its best efforts to provide you with verbal notification of its determination within twenty-four (24) hours after your request was received. The independent review entity will also issue its decision in writing no later than forty-eight (48) hours after the independent review entity provided you with verbal notice of its decision.

If the original request was for an expedited exception, the independent review entity will issue its decision in writing no later than twenty-four (24) hours following its receipt of the request.

SECTION 6 – WHAT IS NOT COVERED

This section includes information on:

- Exclusions; and
- Limitations

Benefit Limitations

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

Exclusions

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

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

- Listed as an Exclusion in this EOC.
- Not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or Benefit policy guidelines.
- Received from a Non-Network Provider unless specifically covered in this EOC or authorized by the Plan.
- Received from an individual or entity that is not recognized by us as a Provider, as defined in this EOC.
- Experimental or Investigational Services. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be an Experimental or Investigational Service. Please refer to the Experimental or Investigational Services Exclusion section, below, for further information on how we determine whether a service is Experimental or Investigational.
- Received to treat any condition, disease, defect, ailment, or Injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this Exclusion does not apply. This Exclusion applies if you receive Workers' Compensation Act benefits in whole or in part. This Exclusion also applies whether or

not you Claim the benefits or compensation. It also applies whether or not you recover from any third party.

- Provided to you as benefits by any governmental unit, unless otherwise required by law or regulation.
- Received to treat any Sickness or Injury that occurs while serving in the armed forces.
- Received to treat a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- Elective abortion, which is an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.
- For court ordered testing or care unless Medically Necessary.
- Health Care Services received while incarcerated due to a felony conviction in a federal, state or local penal institution or required while in custody of federal, state, or local law enforcement authorities due to a felony conviction, including work release programs, unless otherwise required by law or regulation.
- Health Care Services for which you have no legal obligation to pay in the absence of this or like coverage.
- For the following Provider charges listed below:
  - Surcharges for furnishing and/or receiving medical records and reports.
  - Charges for doing research with Providers not directly responsible for your care.
  - Charges that are not documented in Provider records.
  - Charges from an outside laboratory or shop for services in connection with an order involving devices that are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
  - For membership, administrative, or access fees charged by Providers. Examples of administrative fees include, fees charged for educational brochures or calling you to provide your test results.
- Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- Prescribed, ordered or referred by or received from a member of your immediate family.
- For completion of Claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For any travel related expenses, except as authorized by us or specifically stated as a Covered Service in Section 4: *Your Covered Benefits, Transportation and Lodging*.
- For Health Care Services received prior to the date your coverage began under this EOC.
- For Health Care Services received after the date your coverage terminates except as specified in Section 11: *When Coverage Ends*.

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

- For weight loss programs unless specifically listed as covered in this EOC. This Exclusion includes commercial weight loss programs and fasting programs.
- For bariatric surgery, regardless of the purpose it is performed. This includes Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery, Gastroplasty, or gastric banding procedures.
- For Health Care Services to treat complications directly related to bariatric surgery, including Health Care Services that result in an Inpatient Stay or an extended Inpatient Stay, as determined by the Plan. This Exclusion applies when the bariatric surgery was not a Covered Service under this Plan. This exclusion also applies even if the bariatric surgery was performed while the Covered Person was covered by another policy, plan or other benefit program when the bariatric surgery was performed. Directly related means that the Health Care Services were the direct result of the bariatric surgery and would not have been performed in the absence of the bariatric surgery.
- For marital counseling.
- For biofeedback.
- For work place / hiring physicals.
- For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service in Section 4: *Your Covered Benefits* and Section 15: *Vision Services - Pediatric*.
- For vision orthoptic training except as otherwise specifically stated as a Covered Service in Section 15: *Vision Services - Pediatric*.
- For hearing aids or examinations to prescribe or fit them, unless otherwise specified within Section 4: *Your Covered Benefits.*
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- For Health Care Services and associated expenses for Assisted Reproductive Technology (ART) including: artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures or any other treatment or procedure designed to create a Pregnancy, and any related prescription medication treatment. Embryo transport. Donor ovum and semen and related costs including collection and preparation.
- For the reversal of surgical sterilization.
    - Cryo-preservation and other forms of preservation of reproductive materials.
    - Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
    - Services related to surrogacy if the Covered Person is not the surrogate.
    - Services and materials not meeting accepted standards of optometric practices.
- For special lens designs or coatings other than those described in this EOC.

- For replacement of lost/stolen eyewear except as otherwise specifically stated as a Covered Service in Section 15: *Vision Services: Pediatric*.
- For non-prescription (Plano) lenses.
- For two (2) pairs of eyeglasses in lieu of bifocals.
- For insurance of contact lenses.
- For personal hygiene, environmental control, or convenience items including:
  - Air conditioners, humidifiers, air purifiers;
  - Personal comfort and convenience items during an Inpatient Stay such as daily television rental, telephone services, cots or visitor's meals;
  - Charges for non-medical self-care;
  - Purchase or rental of supplies for common household use, such as water purifiers;
  - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
  - Infant helmets to treat positional plagiocephaly;
  - Safety helmets for neuromuscular diseases; or
  - Sports helmets.
- For emergency response systems, unless otherwise authorized by Plan.
- For automatic medication dispensers, unless otherwise authorized by Plan.
- For health club memberships, health spas, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Provider.
- For telephone consultations or consultations via electronic mail or web site, except as required by law or authorized by us.
- For Health Care Services received in an Emergency Room which are not Emergency Health Care Services.
- For eye surgery to correct errors of refraction, such as near-sightedness, including LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
- For self-help training and other forms of non-medical self-care.
- For examinations relating to research screenings.
- For stand-by charges of a Provider.
- For physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes; provided, however, that this Exclusion shall not apply to those Health Care Services for which Benefits have not been exhausted or that have not been covered by another source.

- For private duty nursing services rendered in a Hospital or Skilled Nursing Facility. Private duty nursing services are Covered Services only when provided through the Home Health Care Services Benefit as specifically stated in Section 4: *Your Covered Services.*
- For services and supplies related to the primary diagnosis of male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This Exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Services.
- For services or supplies related to alternative or complementary medicine. Services in this category include acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
- For any services or supplies provided to a person not covered under this EOC in connection with a surrogate Pregnancy.
- For surgical treatment of gynecomastia.
- For treatment of hyperhidrosis (excessive sweating).
- For human growth hormone for children born small for gestational age.
- For drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are Therapeutically Equivalent to an over the counter drug, device, product, or supply.
- For sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
- For treatment of telangiectatic dermal veins (spider veins) by any method.
- For reconstructive services except as specifically stated in the Your Covered Services section of this EOC, or as required by law.
- For nutritional and/or dietary supplements, except as provided in Section 2: *How the Plan Works* or as required by law. This Exclusion includes: those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed Pharmacist.
- Received if the Injury, Illness, or Sickness for which the Health Care Services are rendered resulted from an action or omission for which a governmental entity is liable.
- Not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these

states, we will pay for eligible Covered Services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law.

- For all Adult dental treatment except as specified in Section 4: *Your Covered Benefits*. "Dental treatment" includes: preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including:
  - Extraction, restoration and replacement of teeth.
  - Medical or surgical treatments of dental conditions.
  - Services to improve dental clinical outcomes.
- For Adults - treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service in Section 4: *Your Covered Benefits*.
- For Adult dental implants.
- For Adult dental braces.
- For Adult dental x-rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as provided in Section 4 – *Your Covered Services*. The only exceptions to this are for any of the following:
  - Transplant preparation.
  - Initiation of immunosuppressives.
  - Direct treatment of acute traumatic Injury, cancer or cleft palate.
- For treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly except as set forth in Section 4: *Your Covered Benefits.*
- For oral surgery for Adults that is dental in origin.

Experimental or Investigational Services Exclusion

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

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

- Cannot be legally marketed in the United States without the final approval of the United States Food and Drug Administration, or other licensing or regulatory agency, and such final approval has not been granted; or

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

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

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

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

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

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

We have the authority to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational. Please refer to Section 8*: Complaint Process, Claims Procedures and Adverse Benefit Determination Appeals* for information on how to resolve any issues you have concerning the Plan, Benefit determinations, and coverage and eligibility issues.

SECTION 7 – STAYING HEALTHY

Healthy Living/Health Management Programs

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

What this section includes:

Health and well-being resources available to you, including

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

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

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

NOTE:

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

CareSource24®

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

Care Coordination

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

Care Transitions

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

Reminder Programs

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

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

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

Medication Therapy Management Program

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

Your pharmacist can help with:

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

CareSource On-Line

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

On our website, you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician;
- Search for Network Providers available in your Plan through the online Provider directory;
- Complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;

Registering on CareSource.com

If you have not already registered on our website, simply go to CareSource.com/marketplace. Have your CareSource ID Card handy. The enrollment process is quick and easy.

Visit our website to:

- Make real-time inquiries into the status and history of your Claims;
- View eligibility and Plan Benefit information, including Copayments and Annual Deductibles;
- Order a new or replacement ID Card or print a temporary ID Card.

Want to learn more about a condition or treatment?

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

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

What this section includes:

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

Please contact Member Services at 1-888-815-6446 with any questions you have about your Benefits, including any questions about your coverage and Benefit levels, Annual Deductibles, Coinsurance Copayment, and Annual Out-of-Pocket Maximum amounts, specific claims or services you have received, our Network, and our authorization requirements.

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

The Complaint Process

We have put in place a Complaint Process for the quick resolution of Complaints you submit to us that are unrelated to Benefits or Benefit denials. For purposes of this Complaint Process, we define a Complaint as an expression of unhappiness or dissatisfaction, orally or in writing, concerning any matter relating to any aspect of the Plan's operation. If you have a Complaint concerning the Plan, please contact us.

You may submit your Complaint by sending a letter to us at the following address: CareSource, Attention: Kentucky Member Appeals, P.O. Box 1947, Dayton, OH 45401. Fax: 937-396-3083 or Toll Free: 866-582-0614. You may also submit a Complaint by calling us at 1-888-815-6446. You may also arrange to meet with us in-person to discuss your Complaint.

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

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

Initial Benefit Determinations

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

For purposes of this Section, the following definitions apply:

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

Prior Authorization – An Authorization that must be obtained prior to you receiving a Health Care Service.

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

Retrospective Medical Review - A review of whether a Health Care Service that has already been received is a Covered Service. A review may only be deemed a Retrospective Medical Review if our Prior Authorization was not required and a Predetermination review was not performed. Retrospective Medical Reviews are typically initiated by us. Retrospective Medical Reviews do not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

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

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

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

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

Urgent Review Request - A request for review of any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or in the opinion of a Physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care of treatment that is subject of the review. Urgent care shall also include all requests for hospitalization and outpatient surgery. In addition, a claim involving urgent care also includes any claim that a Physician with knowledge of the member's condition determines is claim involving urgent care.

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

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

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

Timing of Initial Benefit Determinations

We will make our benefit decisions within the timeframes set forth below. Please call Member Services at 1-888-815-6446 with any questions.

Review Request Category	Timeframe for Making Decision
Urgent Care Claims*	As soon as possible taking into account the medical exigencies but within seventy-two (72) hours of our receipt of your request.
Prospective Care Claims **	Within fifteen (15) calendar days of our receipt of your request.
Concurrent Care Claims	Within twenty-four (24) hours of our receipt of your request.
Retrospective Care Claims ***	Within thirty (30) calendar days of our receipt of your request.

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

** **Prospective Care Claims**. The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan or due to matters beyond the Plan's control. If the Plan needs more information before we can make a decision, then the Plan will notify of you. The notice will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

This period may also be extended one time by the Plan, for up to fifteen (15) days, if the Plan determines that such an extension is necessary due to matters beyond the Plan's control and notify you, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the we expect to render a decision.

*** **Retrospective Care Claims**. The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan or due to matters beyond the Plan's control. If the Plan needs more information before we can make a decision, then the Plan will notify of you. The notice will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

This period may also be extended one time by the Plan, for up to fifteen (15) days, if the Plan determines that such an extension is necessary due to matters beyond the Plan's control and notify you, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the we expect to render a decision.

Notification of Initial Benefit Determination

We will provide notification of our decision in accordance with state and federal regulations. Notification may be given by the following methods:

- **Verbal:** Oral notification given to you via telephone (for Urgent Care Claims only), followed by written notification.
- **Written:** Mailed letter or electronic means (including email and fax) given to, at a minimum, the requesting Provider and the Covered Person or his or her Authorized Representative.

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

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

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

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

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

Internal Appeal Process

Adverse Benefit Determination Appeals

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

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

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

CareSource, Attention: Kentucky Member Appeals, P.O. Box 1947, Dayton, OH 45401. Fax: 937-396-3083 or Toll Free: 866-582-0614.

If you or your Authorized Representative would like to appeal a denied Urgent Care Claim, then you may submit your Internal Appeal orally by calling 1-888-815-6446.

This communication, whether done in writing or orally, must include the following information:

1. The Covered Person's name and identification number as shown on the ID Card;
2. The Provider's name;
3. The date of the medical service;
4. The reason you disagree with the Coverage Denial; and
5. Any documentation or other written information to support your request.

NOTE: If the Internal Appeal request was done orally, except for Urgent Care Claim Appeals, the Internal Appeal must be followed up in writing before the Plan will begin to process the Internal Appeal.

Standard Review of an Internal Appeal

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

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

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

The Plan must notify you of our Final Adverse Benefit Determination within fifteen (15) days after receiving the completed Internal Appeal for a Prospective Claim and thirty (30) days after receiving the completed Internal Appeal for a Retrospective Claim.

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

Expedited Review of Internal Appeal

A request for an expedited review of an Internal Appeal may be started orally, in writing, or by other reasonable means available to you or your Provider who has permission to act on your behalf.

You may request an expedited Internal Appeal for:

- Any claim for Health Care Services or treatment with respect to which the application of the time periods for making non-Urgent Care Claim determinations:
  - Could seriously jeopardize your life or health or your ability to regain maximum function, or,
  - In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- Except as provided below, whether a claim meets the above conditions in order to be eligible for expedited Internal Appeal will be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- Any claim that a Physician with knowledge of your medical condition determines is a claim involving Urgent Care Services.
- Any claim when you are hospitalized or, in the opinion of your treating Provider, review of the claim on a non-expedited basis could, in the absence or immediate medical attention, result in any of the following:
  - Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or the unborn child in serious jeopardy;
  - Serious impairment to bodily functions; or

- Serious dysfunction of a bodily organ or part.

We will complete an expedited review of an Internal Appeal as soon as possible given your medical needs, but not later than seventy-two (72) hours after our receipt of the request. We will communicate our decision and all other necessary information by telephone to you, your attending Physician, or the ordering Provider.

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

Exhaustion of the Internal Appeals Process

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

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

External Review Process

Appeal of the Final Adverse Benefit Determination Notice

We provide a process that allows you the right to request an independent External Review of an Adverse Benefit Determination notice. There is no minimum cost of Health Care Services denied in order to qualify for an External Review; however, you must generally exhaust the Plan's Internal Appeal process before seeking an External Review. Any exceptions to this requirement will be included in the notice of the Adverse Benefit Determination.

An External Review will be conducted by either the Kentucky Department of Insurance (“Department”) or an Independent Review Entity (“IRE”), depending on the nature of your Internal Appeal.

If your request for an External Review is based on a Coverage Denial, then the Department will review your External Review.

If your request for an External Review involves medical judgment or medical information, then an IRE will review your External Review.

Request for External Review by the Kentucky Department of Insurance

If you received a Final Adverse Benefit Determination notice which upheld a Coverage Denial, then you may seek review by the Department. You must send a written request to the Department within one hundred twenty (120) days of the date you received the Final Adverse Benefit Determination notice in order to have a Coverage Denial reviewed.

You must send your written request to the following address:

Kentucky Department of Insurance
Coverage Denial Coordinator
P.O. Box 517, Frankfort, KY 40602
502-564-6088

When the Department receives your request for review, the Department should notify the Plan. Within ten (10) Business Days, we will provide the Department with the information they request. Once the Department receives the requested information from us (unless the Department is not able to do so because making a determination requires resolution of a medical issue), the Department will determine whether the service, treatment, drug, or device is specifically limited or excluded under the terms of your health benefit plan.

If the Department determines that the treatment, service, drug, or device is not specially limited or excluded, then the Plan will either (1) cover the service, treatment, drug, or device, or (2) will afford you the opportunity to participate in the External Review process as described below, if the conditions precedent to such a review are met.

If the Department notifies us that the service, treatment, drug, or device is specifically limited or excluded in your health benefit plan, then we will not cover the service, treatment, drug, or device or afford you the opportunity to participate in the External Review process described below, even if the conditions precedent to such review are met.

Request for External Review By Independent Review Entity

Regardless of whether your External Review is to be considered standard, expedited, or experimental or investigational, you or your Authorized Representative must submit a request to us for an External Review to be conducted by an IRE within one hundred twenty (120) days of receiving your Final Adverse Benefit Determination notice.

All External Review requests must be in writing, except for a request for an Expedited External Review, which may be requested orally or electronically. In addition to filing the request for External Review, you will also be required to authorize the release of your medical records as necessary to conduct the External Review. In addition, if you wish to have another person

represent you during the External Review process, then you must submit a written authorization appointing that person as your Authorized Representative.

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

CareSource, Attention: Kentucky Member Appeals, P.O. Box 1947, Dayton, OH 45401.

If you or your Authorized Representative would like to file an expedited External Review, then you may submit your request for expedited External Review orally by calling us at 1-888-815-6446. Fax: 937-396-3083 or Toll Free: 866-582-0614.

This communication (i.e., your request for an External Review), whether done in writing or orally, must include the following information:

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

Within five (5) Business Days of receipt of your request for a standard External Review, the Plan will notify you or your Authorized Representative of whether your request is eligible for External Review and whether your request is complete. If your request for a standard External Review is eligible and complete, then the Plan will initiate the External Review process. If the request for a standard External Review is not complete, then we will inform you in writing and specify what information is needed to make the request complete.

Within twenty-four (24) hours of receipt of your complete request for an expedited External Review, the Plan will notify you or your Authorized Representative that your request is complete and eligible for External Review, and will initiate the External Review process. If the request for an expedited External Review is not complete, then we will notify you of what information is needed to make the request complete.

If we determine that the Adverse Benefit Determination is not eligible for External Review, then we must provide you notification of such decision. You may then file a complaint with the Kentucky Department of Insurance. Regardless of any determination made by the Plan, the Kentucky Department of Insurance may determine that your request is eligible for External Review and may require that the request be referred for External Review. The Department's decision will be made in accordance with the terms of the Plan and all applicable provisions of the law.

NOTE: You will be assessed a one-time filing fee of Twenty-Five Dollars ($25.00) to be paid to the Independent Review Entity. This fee may be waived if the Independent Review Entity determines that the fee creates a financial hardship on you. The fee shall be refunded if the Independent Review Entity finds in your favor. If you submit multiple requests for External Reviews within a one-year period, then you will not have to pay more than Seventy-Five Dollars ($75.00) per year in filing fees. The Plan will be responsible for the rest of the cost associated with the External Review.

External Review Conducted by Independent Review Entity

Standard External Reviews Conducted by Independent Review Entity

An Independent Review Entity will conduct a standard External Reviews in the following instances:

- The Plan has rendered an Adverse Benefit Determination;
- The Internal Appeal process outlined above was completed or jointly waived by you and us or we failed to make a determination within the required timeframe; and
- The Member was covered under this EOC on the date of service or, if a prospective denial, the Member was eligible to receive benefits under this EOC on the date the proposed service was requested.

You will not be afforded an External Review of an Adverse Benefit Determination if:

- The subject of your Adverse Benefit Determination has previously gone through the External Review process and the Independent Review Entity found in favor of us; and
- No relevant new clinical information has been submitted to us since the Independent Review Entity found in favor of us.

NOTE: If either you, your Authorized Representative, or Provider (acting on your behalf) obtains new clinical information regarding your Internal Appeal, then you, your Authorized Representative, or Provider (acting on your behalf) must provide that information to the Plan prior to the initiation of the External Review process described below.

Expedited External Reviews Conducted by Independent Review Entity

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

- If you are hospitalized, or
- If, in the opinion of the treating Provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:
  - Placing your health or, with respect to a pregnant woman, the health of you or your unborn child in serious jeopardy;
  - Subjecting you to severe pain that cannot be adequately managed;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of a bodily organ or part.

Expedited External Reviews are also available if the Final Adverse Benefit Determination notice concerns an admission, availability of care, continued stay, or health care service for which you received emergency services, but have not been discharged from the facility, or involves a medical condition for which the standard External Review time frame would seriously jeopardize your life or health or seriously jeopardize your ability to regain maximum function.

Expedited External Reviews are also available if you are requesting review of a decision that a recommended or requested service is Experimental/Investigative and your Physician certifies in writing that the requested service would be significantly less effective if not promptly initiated.

IRE Assignment

When we initiate an External Review by an IRE, the Kentucky Department of Insurance assigns the review, based upon a rotational system, to an accredited IRE that is qualified to conduct the review based on the type of Health Care Service. An IRE that has a conflict of interest with us, you, your Provider, or the Facility will not be selected to conduct the review.

IRE Review and Decision

The IRE should consider all documents and information considered by us in making the Adverse Benefit Determination, any information submitted by you, and other information such as your medical records, your attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the Plan, the most appropriate practice guidelines, clinical review criteria used by the Plan or our utilization review organization, and the opinions of the IRE's clinical reviewers. The IRE is not bound by any previous decision reached by us.

The IRE assigned to review your standard External Review should provide notice of its decision to either uphold or reverse our determination within twenty-one (21) days from the receipt of all necessary information required from the Plan. An extension of up to fourteen (14) days may be allowed if agreed to by you and the Plan. In no event should the Independent Review Entity take longer than forty-five (45) days to complete its review.

The IRE assigned to review your expedited External Review should provide notice of its decision to either uphold or reverse our determination within twenty-four (24) hours from receipt of all necessary information required from the Plan. An extension of up to twenty-four (24) hours may be allowed if agreed to by you and the Plan. In no event should the Independent Review Entity take longer than seventy-two (72) hours to complete their review.

The Plan will implement the decision of the Independent Review Entity regardless of whether you are still currently enrolled with the Plan. If you have been disenrolled from the Plan, then the Plan is only required to provide the treatment, service, drug, or device that was previously denied by the Plan and later approved by the Independent Review Entity for a period not to exceed thirty (30) days.

If you, your Authorized Representative, or a Provider (acting on your behalf) believes any of the Independent Review Entity’s actions were inappropriate applications of the requirements under Kentucky law, then you, your Authorized Representative, or a Provider (acting on behalf) may

submit a written complaint to the Kentucky Department of Insurance. The Department will review the complaint and will take corrective measures as appropriate.

All records provided to independent review entities are handled as confidential records.

The decision of the Independent Review Entity will be binding on you and us, except to the extent that there are remedies available under applicable state or federal law.

If You Have Questions About Your Rights or Need Assistance

You may contact us by mail or phone. Please call Member Services at 1-888-815-6446, or send correspondence to CareSource, Attention: Kentucky Member Appeals, P.O. Box 1947, Dayton, OH 45401. Fax: 937-396-3083 or Toll Free: 866-582-0614.

You may also contact the Kentucky Department of Insurance at:

Kentucky Department of Insurance
ATTN: Consumer Protection Division
P.O. Box 517
Frankfort, KY 40602-0517
Toll free (KY only) 1-800-595-6053 or 502-564-3630
Deaf/hard-of-hearing 1-800-648-6056
http://insurance.ky.gov

To file a Consumer Complaint, please go to:

http://insurance.ky.gov/online_complaint.aspx?MenuID=3&Div?id=4

Definitions

Definitions. For purposes of this section, the following definitions apply—

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on:

- A determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to health benefit plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review;

- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate;

- A determination of an individual’s eligibility to participate in a plan or health insurance

coverage;

- A determination that a benefit is not a covered benefit;

- Source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or

- Any rescission of coverage whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

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

External Review means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted by an Independent Review Entity (IRE).

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

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

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

Language Services

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

SECTION 9 – COORDINATION OF BENEFITS (COB)

What this section includes:

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

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

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

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

Definitions

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

(1) Health Plan includes: group and nongroup insurance contracts, 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 Health Plan, as permitted by law.

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

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

B. "This Health Plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Health Plans. Any other part of the contract providing health care benefits is separate from This Health Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

When This Health Plan is primary, it determines payment for its benefits first before those of any other Health Plan without considering any other Health Plan's benefits. When This Health Plan is secondary, it determines its benefits after those of another Health Plan and may reduce the benefits it pays so that all Health Plan benefits do not exceed the Primary Health Plan's Maximum Allowable Amount.

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

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

(1) The difference between the cost of a Semi-private Room and a private Hospital room is not an Allowable Expense, unless one of the Health Plans provides coverage for private Hospital room expenses.

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

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

(4) If a person is covered by one Health Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Health Plan that provides its benefits or services on the basis of negotiated fees, the Primary Health Plan's payment arrangement will be the Allowable Expense for all Health Plans. However, if the provider has contracted with the Secondary Health

Plan to Provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Health Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable Expense used by the Secondary Health Plan to determine its benefits.

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

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

F. "Benefit Reserve" means the savings recorded by a Plan for Claims paid for a Member as a Secondary Plan rather than a Primary Plan.

Order of Benefit Determination Rules

When a person is covered by two or more Health Plans, this Plan is a Secondary Plan, which has its benefits determined after those of the other Plan unless:

A. The other Plan has rules coordinating its benefits with those of this Plan; and

B. Both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules which applies:

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

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

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

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

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

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

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above will determine the order of benefits;

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

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

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

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

(d) Joint Custody. If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the Health Plans covering the child shall follow the Order of Benefit Determination rules in Subparagraph (a) or (b) as applicable.

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

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Health Plan, the Health Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Health Plan and the COBRA or state or other federal continuation coverage is the Secondary Health Plan. If the other Health Plan does not have this rule, and as a result, the Health Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled (1) can determine the order of benefits.

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

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

Effect on the Benefits of This Health Plan

When a Member is covered under two or more Plans which together pay more than the Allowable Expense, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is Primary. However, when this Plan is Secondary under the Order of Benefit Determination Rules, benefits payable will be reduced, if necessary, so that combined benefits of all Plans covering you or your Dependent do not exceed the Allowable Expense. When this Plan is Secondary, you will receive credit during the calendar year for the amount by which your benefits are reduced. This credit will not be applied to the extent that it would cause you to receive:

- A combined benefit from all Plans greater than the Allowable Expense; or

- More benefits during a calendar year than you would receive if there were no other coverage.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan. If this Plan is secondary, any Benefit Reserve accumulated for a Member will be used to pay Allowable Expenses of that Member only, not otherwise paid during the Claim Determination Period. The Benefit Reserve, if any, will return to zero at the end of the Claim Determination Period.

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Coordination of Benefits

If you believe that we have not paid a Claim properly, you should first attempt to resolve the problem by contacting us at the phone number listed on your ID card. Please also refer to the appeals procedures listed in this EOC. If you are still not satisfied, you may call the Kentucky Department of Insurance for instructions on filing a consumer complaint. Call 1-800-595-6053, or visit the Department's website at http://insurance.ky.gov/.

SECTION 10 – SUBROGATION AND REIMBURSEMENT

What this section includes:

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

Subrogation – Example

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

When the Plan has paid Benefits for the treatment of Sickness or Injury caused by a third party, and you have a right to recovery or have received recovery from a third party, the Plan has a right to subrogation. This means that the Plan is substituted to and will succeed to any and all legal claims that you may be entitled to pursue against any third party for Benefits for which a third party is considered responsible. The Plan also has a right to be reimbursed from any third party recovery in the amount of Benefits paid on your behalf.

The Plan's subrogation and reimbursement rights shall have first priority, which means that they are paid before any of your other Claims are paid. The Plan 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, no matter how those proceeds are captioned or characterized.

You must notify us promptly of how, when and where an accident or incident resulting in Sickness or Injury to you occurred and all information regarding the parties involved. You must notify us promptly if you retain an attorney related to such an accident or incident. You and your legal representative must cooperate with us, do whatever is necessary to enable us to exercise our subrogation and reimbursement rights, and do nothing to prejudice our rights.

SECTION 11 – WHEN COVERAGE ENDS

What this section includes:

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

Guaranteed Renewable

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

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

You may terminate coverage under this Plan by providing at least fourteen (14) calendar days prior notice to us. Such termination shall be effective fourteen (14) calendar days after we receive your request for termination unless otherwise agreed upon.

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

Notice of Termination and Date of Termination

The Marketplace and Plan will notify you if your coverage ends at least thirty (30) calendar days prior to the last day of coverage, with such effective date determined by the Marketplace when applicable. The notice will set forth the reason for the termination and will tell you the date your coverage under the Plan ends. If you are delinquent on premium payment, the Plan will provide you with notice of such payment delinquency. If your coverage is cancelled, we will return to you any unearned portion of premiums you paid beyond the month in which the cancellation is effective.

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

Reinstatement

This reinstatement provision does not apply if you enrolled in the Plan through the Marketplace. This reinstatement provision only applies to Covered Persons who have directly enrolled with the Plan.

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

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

Benefits after Termination

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

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

In the event that we terminate your coverage while you are receiving Inpatient care in a Hospital, the Plan will continue your coverage until the earliest occurrence of any of the following: (1) your discharge from the Hospital; (2) the determination by your Physician that Inpatient care in the Hospital is no longer Medical Necessary for you; (3) your reaching the limit for contractual Benefits; (4) the effective date of any new coverage you have; or (5) sixty (60) days after your coverage is terminated; provided, however, that the Plan will not continue your coverage for the

Inpatient care if your coverage terminates (a) because you terminate coverage under this Section 11, or (b) if you fail to pay Premium within the applicable Grace Period set forth in Section 2: *How the Plan Works.*

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

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

Rescission

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

Certification of Prior Creditable Coverage

If your coverage is terminated and we are required by law to give you evidence of coverage, you will receive a certification showing when you were covered under the Plan. You may need the document to qualify for another health Plan. Certifications may be requested within 24 months of losing Benefits under this Plan. You may also request a certification be provided to you at any other time, even if you have not lost coverage under this Plan. If you have any questions, please contact Member Services.

SECTION 12 – OTHER IMPORTANT INFORMATION

What this section includes:

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

No Waiting Periods or Pre-Existing Conditions

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

No Lifetime Limits on the Dollar Value of Essential Health Benefits

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

No Annual Limits on the Dollar Value of Essential Health Benefits

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

Your Relationship with CareSource

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

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

CareSource's Relationship with Providers

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

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

Your Relationship with Providers

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

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

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

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

When this Plan provides Benefits for Covered Services that may be legally performed in Kentucky for the practice of osteopath, optometry, chiropractic, podiatry, medicine, psychology, social work or dentistry, such Benefits will not be denied when such Covered Service is rendered by a person licensed in Kentucky as an osteopath, optometrist, Chiropractor, podiatrist, physician, licensed clinical social worker, or dentist, as the case may be.

Claims

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

Written notice of Claim must be given to us within sixty (60) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Member to CareSource or to any authorized agent of CareSource, with information sufficient to identify the Member, shall be deemed notice to us.

Claim Forms

CareSource, upon receipt of a notice of Claim, will furnish to the Member claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the Member claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which Claim is made.

Proof of Loss

Written proof of loss must be furnished to CareSource at our office in case of Claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which CareSource is liable and in case of Claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any Claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

Payment of Claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting payment which may be prescribed herein and effective at the time of payment. If no designation or provision is then effective, any indemnity shall be payable to the estate of the Member. Any other accrued indemnities unpaid at the Member's death may, at the option of CareSource, be paid either to a beneficiary or to the estate. All other indemnities will be payable to the Member.

Interpretation of Benefits

CareSource has the sole authority to:

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

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

Guaranteed Availability and Renewability

We are not obligated to renew or continue Benefits if you fail to pay Premiums; if you perform an act or practice that constitutes Fraud or the making of an intentional misrepresentation; if CareSource ceases to offer the Plan; if you move outside the Service Area, or become otherwise ineligible for Benefits. If we exercise our right not to renew your Benefits under the Plan, it will not take effect until the renewal date occurring on, or after and nearest, each Plan anniversary date and will not be based on any Claim originating while the Plan is in effect.

Your rate under this Plan is guaranteed for a twelve (12) month period. However, if this is your first year as a Covered Person under the Plan, and you enrolled in this Plan after January 1st, then your Benefit Year could be less than 12 months and the rate could change effective on your next renewal, which would be the following January 1st.

If we discontinue this Plan, we will provide notice to you at least ninety (90) days prior to the date that the coverage will end. The notice will tell you about other CareSource plans that you may purchase.

Payment of Benefits

We will pay or deny a Claim within thirty (30) days (or, within sixty (60) days for organ transplant Claims) after we receive a Claim that includes all of the information necessary to process the Claim. At the time of acknowledgement of an electronic Claim (within forty-eight (48) hours of receiving an original or corrected Claim) or a non-electronic Claim (within twenty (20) calendar days of receipt of an original or corrected Claim, we shall notify the applicable person of any additional supporting information that is required in order to process the Claim. This notice will detail the supporting documentation needed. We will process a corrected Claim within thirty (30) days of receiving the additional supporting documentation. If we fail to pay Claims according to these time frames, we may have to pay interest to the Provider. You and your Provider will be notified when a Claim is denied. The notification will include the reason(s) for the denial.

Explanation of Benefits

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

Legal Action

You may not bring any suit on a Claim until at least (60) days after the required Claim document is given. You may not bring any suit more than three (3) years after the date of submission of a proof of loss.

Information and Records

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided Health Care Services to you to furnish CareSource with all information or copies of

records relating to the Health Care Services provided to you. CareSource has the right to request this information at any reasonable time. CareSource may request additional information from you to decide your Claim for Benefits. Such information and records will be considered confidential.

Incentives to Providers

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

Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality measures, Covered Person satisfaction, and/or cost-effectiveness; or
- A practice called capitation, which is when a group of Network Providers receives a monthly payment from CareSource for each Covered Person who selects a Network Provider within the group to perform or coordinate certain Health Care Services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

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

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours, but CareSource recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID Card if you have any questions.

Rebates and Other Payments

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

Workers' Compensation Not Affected

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

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

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

Women's Health and Cancer Rights Act Notice

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

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

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

Physical Examination and Autopsy

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

Genetic Screening

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

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

Legal Contract

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

Policy is Not a Medicare Supplemental Policy

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

Medicare

Any Health Care Services covered under both this Plan and Medicare will be paid according to Medicare secondary payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines. As a Medicare secondary payor, benefits under this Plan shall be determined after those of Medicare. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare, we will calculate benefits as if they had enrolled. The benefits under this Plan for Covered Persons age 65 and older or Covered Persons otherwise eligible for Medicare do not duplicate any benefit for which Covered Persons are entitled under Medicare, except when federal law requires us to be the primary payor. Where Medicare is the primary payor, all sums payable by Medicare for Health Care Services provided to Covered Persons shall be reimbursed by or on behalf of the Covered Persons to us to the extent we have made payment for such Health Care Services.

Limitation of Action

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

Entire Contract: Changes

This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No agreement in conflict with, modifying, or extending this policy is valid unless in writing and made a part of this policy. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. In the event that we make a material modification to this policy other than during the renewal or reissuance of coverage, we will provide notice of the material modification to you no later than sixty (60) calendar days prior to the date on which the material modification will become effective. The requirements of this paragraph do not apply if we grant additional benefits to policyholders which do not require an increase in premium rates or a reduction or restriction in coverage.

Misstatement of Information

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

Non-Discrimination

In compliance with state and federal law, we shall not discriminate on the basis of age, gender, color, race, disability, marital status, sexual preference, religion affiliation, or public assistance status.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of Kentucky when this EOC was issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Severability

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

Waiver and Oral Statements

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

Non-Assignment

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

Clerical Errors

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

Circumstances Beyond the Plan's Control

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

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

Under such circumstances, the Plan and Network Providers will provide the Health Care Services covered by this EOC as far as is practical under the circumstances and according to their best judgment; however, the Plan and Network Providers will accept no liability or obligation for delay, or failure to provide or arrange Health Care Services if the failure or delay is caused by events or circumstances beyond the control of the Plan.

Time Limit on Certain Defenses

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

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

For purposes of any reinstatement of this Policy, we may contest coverage under the Policy on account of the applicant’s fraud or material misrepresentation only if fraud or material

misrepresentation was contained in the reinstatement application, and then only for the period during which the Policy was reinstated.

Legal Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Change of Beneficiary

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

Time of Payment of Claims

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid within thirty (30) days of receipt of due written proof of the loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid within thirty (30) days of receipt of due written proof.

Incarcerated Persons Coverage

When a unit of local government or regional jail authority provides or facilitates Health Care Services for a Covered Person who is confined in the jail, holdover, or regional jail and who has not been convicted as a felon, the Plan shall be the primary payor of Medically Necessary Health Care Services provided that the Benefits shall be only for Covered Services, and provided that all Premiums have been paid.

SECTION 13 – GLOSSARY

What this section includes:

- Definitions of terms used throughout this EOC

Active Course of Treatment means any of the following:

(1) An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted;

(2) An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the Covered Person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;

(3) The second or third trimester of pregnancy, through the postpartum period; or

(4) An ongoing course of treatment for a health condition for which a treating Provider attests that discontinuing care by the Provider would worsen the condition or interfere with anticipated outcomes.

Adult means a person who is at least twenty-one (21) years old.

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

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

Alternate Facility means a freestanding health care facility that is not a Hospital or a Facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. An Alternate Facility provides one or more of the following Health Care Services on an Outpatient basis, as permitted by law: pre-scheduled surgical services, Emergency Health Care Services, Urgent Care Services, pre-scheduled rehabilitative, laboratory, or Diagnostic Services. An Alternate Facility may also provide Behavioral Health Care Services on an Outpatient, intermediate or Inpatient basis.

Ambulance means a licensed ambulance service that is designed, equipped, and used only to transport a Covered Person with a Sickness or Injury, provided it is staffed by Emergency medical technicians, paramedics, or other certified first responders. An Ambulance may transport a Covered Person by ground, water, fixed wing air, or rotary wing air transportation. An ambullete service is not an Ambulance regardless of whether it meets certain criteria set forth above.

Ambulance Services means transportation by an Ambulance of a Covered Person who has a Sickness or Injury.

Amendment means any written changes or additions to this EOC. Amendments are subject to all conditions, limitations, and Exclusions of the Plan, except for those that are changed by the Amendment. CareSource at all times reserves the right to make Amendments.

Annual Deductible means the amount you must pay for Covered Services in a Benefit Year before we will begin paying for Benefits in that Benefit Year. Copayments do not count towards the Annual Deductible. Amounts paid toward the Annual Deductible for Covered Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. The limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. Network Benefits for Preventive Health Care Services are never subject to payment of the Annual Deductible.

Annual Out-of-Pocket Maximum means the maximum amount you pay in a Benefit Year relating to obtaining Benefits. When you reach the Annual Out-of-Pocket Maximum, Benefits for Covered Services that apply to the Annual Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of the Benefit Year. Copayments and Coinsurance for Covered Services will apply to your Annual Out-of-Pocket Maximum, unless otherwise noted below.

The following costs will never apply to the Annual Out-of-Pocket Maximum:

- Any charges for services that are not Covered Services;
- Coinsurance amounts for Covered Services available by an optional Rider/Enhancement, unless specifically stated otherwise in the Rider/Enhancement; and
- Copayments for optional dental and vision benefits or any other optional Rider/Enhancement.

Even when the Annual Out-of-Pocket Maximum has been reached, you will still be required to pay:

- Any charges for Non-Covered Services;
- Charges that exceed Eligible Expenses;
- Copayments and Coinsurance amounts for Covered Services available by an optional Rider/Enhancement, unless specifically stated otherwise in the Rider/Enhancement; and

- The amount of any reduced Benefits if you do not obtain authorization from us when required to do so under the terms of the Plan.

Applied Behavioral Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Authorized Representative means an individual who represents a Covered Person in an internal appeal or external review process of an Adverse Benefit Determination and who is any one of the following:

- A person to whom you have given express, written consent to represent you in an internal appeals process or external review process of an Adverse Benefit Determination;
- A person authorized by law to provide substituted consent for you;
- A family member or a treating health care professional when, and only when, you are unable to provide consent.

Autism Spectrum Disorder means any of the following pervasive developmental disorders as defined by the most current version of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association): Autism; Asperger's Disorder; or other condition that is specifically categorized as a pervasive developmental disorder in the *Manual*.

Behavioral Health Disorder means those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association).

Behavioral Health Care Services means Health Care Services for the diagnosis and treatment of Behavioral Health Disorders, alcoholism and Substance Use Disorders that are listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association), unless those services are specifically excluded. The fact that a condition or disorder is listed in the current *Manual* does not mean that treatment for the condition is a Covered Service.

Benefits or Benefit means your right to payment for Covered Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations, and Exclusions of the Plan, including this EOC and any attached Riders/Enhancements and Amendments.

Benefit Year means the calendar year for which you have coverage under the Plan.

Brand-name Drug means a Prescription Drug that is either manufactured and marketed under a trademark or name by a specific drug manufacturer or identified by CareSource as a Brand-name Drug based on available data resources (including, but not limited to, First DataBank) that classify drugs as either Brand-name or Generic based on a number of factors. Products identified as "brand name" by the manufacturer, Pharmacy, or your Physician may not be classified as Brand-name Drug by the PBM.

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

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

CareSource24® means CareSource's nurse help line, for non-Emergency health situations, which Covered Persons can call 24 hours a day, seven days a week, including holidays. The call is free and confidential. Covered Persons speak directly with a registered nurse about their symptoms or health questions. The nurse will quickly assess your situation and help you choose the most appropriate action. A fax will then be sent to the CareSource Covered Person's PCP to help him or her coordinate better care for the CareSource Covered Person.

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

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

Coinsurance means the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Services after the Annual Deductible is satisfied (*see* Section 2).

Congenital Anomaly means a physical developmental defect that is present at birth and is identified within the first 12 months of birth.

Copayment means the charge, stated as a flat dollar amount, that you are required to pay for certain Covered Services (*see* Section 2).

Cosmetic Procedures means procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Person means an individual, including you or your Dependent, who is properly enrolled by the Marketplace and/or the Plan and for whom the Plan is obligated to pay Benefits or provide services. Often, a Covered Person is referred to as “you.”

Covered Services means those Health Care Services that are (1) covered by a specific Benefit provision of the Plan; (2) not Excluded under the Plan; and (3) determined to be Medically Necessary per the Plan's medical policies and nationally recognized guidelines and that we determine to be all of the following: Provided for the purpose of preventing, diagnosing, or treating a Sickness, Injury, Behavioral Health Disorder, Substance Use Disorder, or their symptoms; consistent with nationally recognized scientific evidence, as available, and prevailing medical standards and clinical guidelines, as described below; and not provided for the convenience of you, a Provider, or any other person. In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings: "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community. "Prevailing medical standards and clinical guidelines" means nationally recognized professional

standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

Custodial Care means care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an Sickness or Injury. Custodial Care is care that cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Custodial Care includes, but is not limited to: assistance with walking, bathing, or dressing; transfer or positioning in bed; normally self-administered medicine; meal preparation; feeding by utensil, tube, or gastrostomy; oral hygiene; ordinary skin and nail care; catheter care; suctioning; using the toilet; enemas; and preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel. Custodial Care includes maintenance care provided by a Covered Person's family, friends, health aides, or other unlicensed individuals after an acute medical event when such Covered Person has reached the maximum level of physical or mental function. In determining whether an individual is receiving Custodial Care, the factors considered are the level of care and medical supervision required and furnished.

Dependent means a person who meets the requisite criteria listed in Section 1: *Eligibility Requirements*.

Designated Pharmacy means a Pharmacy that has entered into an agreement with CareSource or with an organization contracting on its behalf, to provide specific Prescription Drugs. The fact that a Pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Diagnostic Services means Health Care Services performed on a Covered Person who is displaying specific symptoms in order to detect or monitor a disease or condition. A Diagnostic Service also includes a Medically Necessary Preventive Health Care Services screening test that may be required for a Covered Person who is not displaying any symptoms, if, and only if, it is ordered by a Provider.

Domiciliary Care means care provided in a residential institution, treatment center, halfway house, or school because a Covered Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Durable Medical Equipment means medical equipment that can withstand repeated use, is not disposable, is used to serve a medical purpose with respect to treatment of a Sickness, Injury, or their symptoms, is of use to a person only in the presence of a disease or physical disability, is appropriate for use in the home, and is not implantable within the body.

Eligible Expenses means the amount we will pay for Covered Services, incurred while the Plan is in effect, determined as stated below:

> Eligible Expenses are our contracted fee(s) with our Network Providers for Covered Services. When Covered Services are received from Non-Network Providers as a result of an emergent/urgent condition or as otherwise arranged by your PCP or other Network Physician and approved by us, Eligible Expenses are billed charges unless a lower amount is negotiated.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies: As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association; as reported by generally recognized professionals or publications; as used for Medicare; or as determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Individual means an applicant for an individual policy who has eighteen (18) months prior creditable coverage, with no break in coverage of more than sixty-three (63) days, the most recent of which was an employment related group plan sponsored by an employer, church or governmental plan. Certain children are Eligible Individuals, even if they do not have a full 18 months of creditable coverage, provided that they were covered under creditable coverage within thirty (30) days of birth, adoption, or placement for adoption and have not had a sixty-three (63) day break in coverage.

Emergency Medical Condition or Emergency means

(1) A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in :

(a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part; or

(2) With respect to a pregnant woman who is having contractions:

(a) A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or

(b) A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of Emergencies are: heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures, and convulsions.

Emergency Health Care Services means Health Care Services necessary for the treatment of an Emergency.

Emergency Room means the section, department or facility of a Hospital that either: (1) is licensed by the state as an emergency room; (2) held out to the public as providing treatment for Emergency Medical Conditions; or (3) on one-third of the visits to the department in the

preceding calendar year actually provided treatment for Emergency Medical Conditions on an urgent basis.

Essential Health Benefits means ambulatory patient services, Emergency Health Care Services, Inpatient Services, Maternity Services, newborn care, Substance Use Disorders Treatment, including Behavioral Health Care Services, Prescription Drugs, Preventive Health Care Services and chronic disease management, and pediatric services, including oral and vision care as further defined in 42 U.S.C § 18022 and as further defined by the Commonwealth of Kentucky.

Exclusions, Exclusion or Excluded means Health Care Services that are not Covered Services.

Experimental or Investigational Services or **Experimental or Investigational** means medical, surgical, diagnostic, psychiatric, Substance Use Disorders Treatment or other Health Care Services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following: not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; subject to review and approval by any institutional review board for the proposed use; the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight (this includes diagnostic testing for purposes of possible inclusion in a clinical trial); or any service billed with a temporary procedure code. Devices that are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational. If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may determine that an Experimental or Investigational Service meets the definition of a Covered Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but an Unproven Service, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Facility means an appropriately licensed Hospital; nursing home; county home or a county nursing home; a freestanding dialysis center; a freestanding Inpatient Rehabilitation Facility; an ambulatory surgical facility; a freestanding cardiac catheterization facility; a freestanding birthing center; a freestanding or mobile diagnostic imaging center; a freestanding radiation therapy center. A health care facility does not include the offices of private Physicians and dentists whether for individual or group practice, an institution for the sick that is operated exclusively for patients who use spiritual means for healing and for whom the acceptance of medical care is inconsistent with their religious beliefs, accredited by a national accrediting organization, exempt from federal income taxation under section 501 of the Internal Revenue Code of 1986, 100 Stat. 2085, 26 U.S.C.A. 1, as amended.

Family Planning Services mean educational, comprehensive medical or social activities which enable individuals, including minors, to select the means by which they can anticipate and attain their desired number of children and the spacing and timing of their births.

Fraud means intentionally, or knowingly and willfully, attempting to execute or participate in a scheme or action to falsely obtain unfair or unlawful financial or personal gain from any health care benefit program. Fraud may include, but is not limited to: seeking reimbursement for services not rendered; selling Prescription Drugs that were prescribed to you to someone else; misrepresenting the date a service was provided; misrepresentation of services (*e.g.*, misrepresenting who rendered the service, the condition or diagnosis of the patient, the charges involved, or the identity of the Provider or recipient); seeking reimbursement for excessive, inappropriate, or unnecessary testing or other services; receiving kickbacks for making a referral or for receiving services related to the referral; altering Claim forms, electronic records, or medical documentation; improper use of the Plan ID Card; or providing false information or withholding accurate information relating to eligibility for coverage under this Plan.

Generic Drug means a Prescription Drug that is either:

Chemically equivalent to a Brand-name Drug; or

Identified by CareSource as a Generic Drug based on available data resources, including, but not limited to, First DataBank, that classify drugs as either brand-name or generic based on a number of factors. Products identified as a "generic" by the manufacturer, Pharmacy or your Physician may not be classified as a Generic Drug by the PBM.

Grace Period means the time period set forth in Section 2: *How the Plan Works*.

Grievance means a written complaint submitted by or on behalf of a Covered Person.

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

Health Care Services means services, supplies, or pharmaceutical products for the diagnosis, prevention, treatment, cure, or relief of health condition, Sickness, Injury, or disease.

Home Health Care Agency means a program or organization authorized by law to provide Health Care Services in the home.

Home Health Care Services means any form of care given within the home. This home care can range from care provided by a home health aide, home health nurse, companion, or caregiver and includes intermittent care, respite care, and home therapies. The term home care covers both medical and non-medical forms of care.

Hospital means an institution, operated as required by law, that is all of the following: is primarily engaged in providing Health Care Services, on an Inpatient basis, for the acute care and treatment of injured or sick individuals; care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; has 24-hour nursing services. A Hospital does not include a place devoted primarily to rest, Custodial Care, or care of the aged and is not a nursing home, convalescent home, or similar institution.

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

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

Inpatient means relating to a patient who has been admitted to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility.

Inpatient Services means Health Care Services relating to a patient admitted to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility.

Inpatient Rehabilitation Facility means a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation Health Care Services (*e.g.*, physical therapy, occupational therapy and/or speech therapy) on an Inpatient basis, as authorized by law.

Inpatient Stay means an uninterrupted confinement following formal admission to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility.

Insurer means any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation or ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

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

Maternity Services means Health Care Services provided in relation to Pregnancy and delivery of a newborn child. Maternity Services include care during labor, birthing, prenatal care, and postpartum care.

Maximum Allowable Amount means the maximum amount that the Plan will allow and provide Benefits for Covered Services you receive.

Medically Necessary/Medical Necessity means Health Care Services that are determined to be medically appropriate in accordance with the Plan's medical policies and nationally recognized guidelines; are not Experimental or Investigational Services; are necessary to meet the basic health needs of the Covered Person; are rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service; are consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by us; are consistent with the diagnosis of the condition; are required for reasons other than the convenience of the Covered Person or his/her Physician; and are demonstrated through prevailing peer-reviewed medical literature to be either: (a) safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed or (b) safe with promising efficacy for treating a life-threatening Sickness or condition in a clinically controlled research setting using a specific

research protocol that meets standards equivalent to those defined by the National Institutes of Health. (For purposes of this definition, the term "life threatening" is used to describe Sickness or conditions that are more likely than not to cause death within one (1) year of the date of the request for treatment.) The fact that a Physician has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an Injury, Sickness, or Behavioral Health Disorder, or the fact that the Physician has determined that a particular Health Care Service is Medically Necessary or medically appropriate does not mean that the procedure or treatment is a Covered Service under the Plan. The definitions of Medically Necessary and Medical Necessity used in this EOC relate only to Benefits and may differ from the way in which a Physician engaged in the practice of medicine may define Medically Necessary or Medical Necessity.

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

Member has the same meaning as Covered Person.

Member Services means the part of CareSource devoted to answering questions and assisting Members find and use the services offered by CareSource.

Network means the group of Providers who have agreed with Plan to provide Health Care Services to Covered Persons at a contracted rate.

Network Benefits, for Physician Health Care Services, are Benefits for Covered Services that are provided by or under the direction of a Physician who is a Network Provider in his or her office or at a Facility that is a Network Provider. For Facility services, these are Benefits for Covered Services that are provided at a Facility that is a Network Provider by a Physician who a Network Provider or other Network Provider. Network Benefits include Emergency Health Care Services.

Network Provider means a Provider who has entered into a contractual arrangement with us or is being used by us, or another organization that has an agreement with us, to provide certain Covered Services or certain administration functions for the Network associated with this EOC. A Network Provider may also be a Non-Network Provider for other Health Care Services or products that are not covered by the contractual arrangement with us as Covered Services. In order for a Pharmacy to be Network Provider, it must have entered into an agreement with the Pharmacy Benefit Manager to dispense Prescription Drugs to Covered Persons, agreed to accept specified reimbursement rates for Prescription Drugs, and been designated by the PBM as a Network Pharmacy.

Non-Covered Services means those Health Care Services that are not Covered Services under this EOC.

Non-Network Provider means a Provider who is not in the Plan’s Network.

Outpatient means relating to a patient who has not been admitted to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility.

Outpatient Services means Health Care Services other than Inpatient Services.

PBM means a pharmacy benefits management company that we contract with to administer your pharmacy Benefits. The PBM has a nationwide network of retail pharmacies, a mail service pharmacy, and a specialty pharmacy.

PCP means Primary Care Provider, which is a Network Physician, Network Physician group practice, advanced practice nurse, or advanced practice nurse group practice trained in family medicine (general practice), internal medicine, or pediatrics that you select to be responsible for providing or coordinating all Covered Services for Network Benefits.

Pharmacy an establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

Pharmacy and Therapeutics Committee means the committee that CareSource designates for, among other responsibilities, classifying Prescription Drugs into specific tiers on the Prescription Drug List.

Physician means any Doctor of Medicine, "M.D.," or Doctor of Osteopathy, "D.O.," who is properly licensed and qualified by law.

Plan means the CareSource Plan.

Pregnancy includes all of the following: prenatal care; postnatal care; childbirth; and any complications associated with Pregnancy.

Premium means the periodic fee required for each Covered Person, in accordance with the terms of the Plan.

Prescription Drug means a medication, product, or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, only be dispensed using a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of the Plan, Prescription Drugs include:

- Inhalers (with spacers);
- Insulin;

The following diabetic supplies:

- Insulin syringes with needles;
- Blood testing strips - glucose;
- Urine testing strips - glucose;
- Ketone testing strips and tablets;

- Lancets and lancet devices; and
- Immunizations administered in a Pharmacy

Prescription Drug Cost means the rate the Pharmacy Benefit Manager has agreed to pay its Pharmacies that are Network Providers, including a dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Pharmacy that is a Network Provider.

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to periodic review and modification (generally quarterly, but no more than six (6) times per Benefit Year). You may determine to which tier a particular Prescription Drug has been assigned by contacting CareSource at the toll-free number on your ID Card or by logging onto **CareSource.com**.

Preventive Health Care Services means routine or screening Health Care Services that are designated to keep you in good health and to prevent unnecessary Injury, Sickness, or disability, including but not limited to the following as may be appropriate based on your age and/or gender: Evidence-based items or Health Care Services with an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF); immunizations for routine use in children, adolescents, and adults with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-informed preventive care screenings for infants, children, and adolescents provided in guidelines supported by the Health Resources and Services Administration (HRSA); and evidence-informed preventive care and screening for women provided in guidelines supported by HRSA and not otherwise addressed by the USPSTF. The complete list of recommendations and guidelines can be found at: http://www.HealthCare.gov/center/regulations/prevention.html and the other websites listed under Section 4: *Your Covered Services, Preventive Health Care Services* (collectively, the "List"). The List will be continually updated to reflect both new recommendations and guidelines and revised or removed guidelines.

Provider means a duly licensed person, Pharmacy, or Facility that provides Health Care Services within the scope of an applicable license and is a person, Pharmacy, or Facility that the Plan approves. This includes any Provider rendering Health Care Services that are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons, Pharmacies, and Facilities listed below. If you have a question about a Provider not shown below, please call the number on the back of your ID Card.

- **Alcoholism Treatment Facility** - A Facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.
- **Alternative Care Facility** – A non-Hospital health care Facility, or an attached Facility designated as free standing by a Hospital that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;

  - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A Facility, with an organized staff of Physicians, that:
  - Is licensed as such, where required;
  - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
  - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
  - Does not provide Inpatient accommodations; and
  - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.
- **Clinical Nurse Specialists** whose nursing specialty is Mental Health Day Hospital - A Facility that provides day rehabilitation services on an Outpatient basis.
- **Dialysis Facility** - A Facility that mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. A Dialysis Facility is not a Hospital.
- **Drug Abuse Treatment Facility** - A Facility that provides detoxification and/or rehabilitation treatment for drug abuse.
- **Home Health Care Agency** - A Facility, licensed in the state in which it is located, that:
  - Provides skilled nursing and other services on a visiting basis in the Covered Person's home; and
  - Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- **Home Infusion Therapy Provider** – Services that may include:
  - Skilled nursing services;
  - Prescription Drugs;
  - Medical supplies and appliances in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.
- **Hospice** - A coordinated plan of home, Inpatient, and Outpatient care that provides palliative and supportive medical and other Health Care Services to terminally ill patients, an interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician, and care is available 24 hours a day, seven days a week. A Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals that:
    - Provides room and board and nursing care for its patients;
    - Has a staff with one or more Physicians available at all times;
    - Provides 24-hour nursing service;
    - Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of Sickness or Injury; and
    - Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

  The term Hospital does not include a Provider, or that part of a Provider, used mainly for:
    - Nursing care;
    - Rest care;
    - Convalescent care;
    - Care of the aged;
    - Custodial Care;
    - Educational care;
    - Treatment of alcohol abuse; or
    - Treatment of drug abuse
    - Independent Social Workers
- **Outpatient Psychiatric Facility** - A facility that mainly provides Diagnostic Service and therapeutic services for the treatment of Behavioral Health Conditions on an Outpatient basis.
- **Pharmacy** – An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order.
- **Physician** - A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), Chiropractor (spinal column and other body structures), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or optometrist (eye and sight specialist).
- **Professional Clinical Counselors**
- **Professional Counselors**
- **Psychiatric Hospital** - A facility that, for compensation of its patients, is primarily engaged in providing Diagnostic and therapeutic services for the Inpatient treatment of Behavioral Health Conditions. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Psychiatrist** – A licensed clinical psychiatrist. In states where this is no licensure law, a psychiatrist must be certified by the appropriate professional body.
- **Psychologist** - A licensed clinical psychologist. In states where there is no licensure law, the psychologist must be certified by the appropriate professional body.
- **Rehabilitation Hospital** - A Facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or Injury to achieve some reasonable level of functional ability and services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Retail Health Clinic** - A Facility that provides limited basic medical care services to Covered Persons on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.
- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, that:
  - Mainly provides Inpatient Services for persons who are recovering from an Sickness or Injury;
  - Provides care supervised by a Physician;
  - Provides 24-hour per day nursing care supervised by a full-time Registered Nurse;
  - Is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
  - Is not a rest, educational, or custodial Provider or similar place.
- **Social Worker** - A licensed clinical social worker. In states in which there is no licensure law, the social worker must be certified by the appropriate professional body.
- **Supplier of Durable Medical Equipment, Prosthetic Appliances, and/or Orthotic Devices**
- **Urgent Care Center** - A licensed health care Facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Health Plan means a health plan offering on the Marketplace that satisfies the requirements set forth under the Affordable Care Act at 42 U.S.C. § 1802(a)(1).

Record means any written, printed, or electronically recorded material maintained by a Provider in the course of providing Health Care Services to a patient concerning the patient and the

services provided. Record also includes the substance of any communication made by a patient to a provider in confidence during or in connection with the provision of Health Care Services to a patient or information otherwise acquired by the Provider about a patient in confidence and in connection with the provision of Health Care Services to a patient.

Rescission means a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuation of coverage is not a Rescission if the cancellation or discontinuance of coverage has only a prospective effect. Rescission is allowed if it is due to: failure to timely pay required Premiums or contributions toward the cost of coverage; Fraud or intentional misrepresentation of a material fact; resulting in the ex-spouse no longer being eligible for coverage.

Residential Treatment Program means Behavioral Health Treatment, which does not meet the definition of Inpatient Hospital care, but requires a patient to reside at a certified or licensed residential treatment facility for the duration of the treatment period. Treatment programs are designed to treat groups of patients with similar Behavioral Health Disorders, living within a supportive 24-hour community (*e.g.*, a 28-day alcohol rehabilitation program).

Rider/Enhancement means any attached written description of additional Covered Services not described in Sections 1 – 12 of this EOC. Covered Services provided by a Rider/Enhancement may be subject to payment of additional Premiums by the Covered Person. Riders/Enhancements are subject to all conditions, limitations, and Exclusions of the Plan except for those that are specifically amended in the Rider/Enhancement.

Schedule of Benefits means the written description of the Benefits that are available for Covered Services that is provided to you when you are enrolled under the Plan.

Semi-private Room means a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Service, the difference in cost between a Semi-Private Room and a private room is a Benefit only when a private room is Medically Necessary or when a Semi-private Room is not available.

Service Area means the geographic area we serve approved by the appropriate regulatory agency and in which we have Network Providers. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Sickness means physical sickness, disease or Pregnancy. The term Sickness as used in this EOC does not include Behavioral Health Disorder or Substance Use Disorders, regardless of the cause or origin of the Behavioral Health Disorder or Substance Use Disorder.

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

Stabilize means to provide treatment that assures that no material deterioration of a Covered Person's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

In the case of a woman having contractions, "Stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

Substance Use Disorder means those alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association).

Substance Use Disorders Treatment means Health Care Services for the diagnosis and treatment of Substance Use Disorders. Substance Use Disorders Treatment includes Health Care Services for the prevention, treatment, and rehabilitation for Covered Persons who abuse alcohol or other drugs.

Terminal Illness means a medical condition for which a Covered Person has a medical prognosis that his or her life expectancy is six (6) months or less if the condition runs its normal course, as certified by the Covered Person's Physician.

Therapeutically Equivalent means when Prescription Drugs can be expected to produce essentially the same therapeutic outcome and toxicity.

United States means the country commonly called the United States (US or U.S.) or America, consisting of fifty (50) states and the Federal District of Washington D.C.

Unproven Service or Unproven means Health Care Services, including medications that are not consistent with conclusions of prevailing medical research, that demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs: (a) well-conducted randomized controlled trials (two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received) or (b) well-conducted cohort studies (patients who receive study treatment are compared to a group of patients who receive standard therapy and the comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures, and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one (1) year of the request for treatment) we may determine that an Unproven Service meets the definition of a Covered Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Services means treatment of an unexpected Sickness or Injury that is not life-threatening but requires Outpatient medical care that cannot be postponed and requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Utilization Management means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the plan. The system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures, and retrospective review.

SECTION 14 – SCHEDULE OF BENEFITS

ATTACHED

SECTION 15 – DENTAL & VISION SERVICES - PEDIATRIC

The information below is specific to the Plan's coverage for pediatric dental and vision Benefits provided up to the end of the month in which a child twenty-one (21) years of age ("Pediatric Dental & Vision Services").

Pediatric Dental Services

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

All exams, oral evaluations and treatments such as fluorides and some images are combined under one limitation under the Plan. Periodic oral exams (D0120) Oral evaluations (D0140) and Comprehensive oral exams (D0150, D0180) are combined and limited to two (2) exams per Benefit Year.

The Plan provides Benefits for the following pediatric dental services.

- **Preventive Services -** Covered in full as part of your Essential Health Benefits.
  - Dental Prophylaxis (Cleanings) - limited to two (2) times per twelve (12) months
  - Fluoride Treatments - limited to two (2) times per (12) months done in conjunction with dental prophylaxis
  - Sealants (protective coating) - limited to one (1) per first or second permanent molar every thirty-six (36) months

- **Diagnostic Services**
  - Intraoral Bitewing Radiographs (Bitewing x-ray) - limited to four (4) films per twelve (12) months
  - Intra/Extra oral X-rays - limited to two (2) films per twelve (12) months
  - Panorex Radiographs (Full jaw x-ray) or Complete Series (full set of x-rays) - limited to one (1) time per twelve (12) months
  - Periodic Oral Evaluation (checkup exam) - Limited to two (2) times per twelve (12) months
  - Minor palliative treatment of pain

- **Space Maintainers -** Benefits includes all adjustments within six (6) months of installation
  - Space Maintainers – limited to two (2) per twelve (12) months

- **Minor Restorative Services, Endodontics, Periodontics, & Oral Surgery**
  - Amalgam Restorations
  - Composite Resin Restorations - limited to anterior (front) teeth only
  - Endodontics (root canal therapy) - limited to one (1) per tooth per lifetime
  - Periodontal Surgery (gum surgery) - limited to (1) time per quadrant per twelve (12) months

- Scaling & Root Planning (Deep Cleanings) - limited to one (1) time per quadrant per twelve (12) months
- Periodontal Maintenance (gum maintenance) - limited to two (2) time per twelve (12) month period following active and adjunctive periodontal therapy with the prior twenty-four (24) months – exclusive of gross debridement
- Simple Extractions (simple tooth removal) - limited to one (1) time per tooth per lifetime
- Oral surgery, including surgical extraction

- **Adjunctive Services**
  - General Services (including Emergency Treatment) - Covered as a separate Benefit only if no other Covered Service was performed, except for x-rays
  - General anesthesia is a Covered Service when Medically Necessary
  - Occlusal guard limited to one (1) guard every twelve (12) months

- **Major / Comprehensive Services**
  - Inlays/Onlays/Crowns (Partial to Full Crowns) - limited to one (1) time per tooth per sixty (60) months
  - Fixed Prosthetics (Bridges) - limited to one (1) time per tooth per sixty (60) months
  - Removable Prosthetics (Full or partial dentures) - Limited to one (1) per sixty (60) months
  - Relining and Rebasing Dentures - limited to relining/rebasing performed more than six (6) months after initial insertion - Limited to one (1) time per twelve (12) months
  - Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns - limited to repairs or adjustments performed more than twelve (12) months after the initial insertion - Limited to one (1) per six (6) months

- **Implant Services** - All Covered Services below are limited to one (1) time per tooth per sixty (60) months:
  - Implant Placement
  - Implant Supported Prosthetics
  - Implant Maintenance Procedures - Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis.
  - Repair Implant Supported Prosthesis By Report
  - Abutment Supported Crown (Titanium) or Retainer Crown for FPD – Titanium
  - Repair Implant Abutment by Support
  - Radiographic/Surgical Implant Index by Report

- **Orthodontic Services -** There is a lifetime maximum for these Covered Services.
  - Limited orthodontic treatment of the primary dentition
  - Limited orthodontic treatment of the transitional dentition
  - Limited orthodontic treatment of the adolescent dentition
  - Interceptive orthodontic treatment of the primary dentition

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

The Plan will also provide Benefits for comprehensive orthodontic treatment in the following areas: (1) cleft lip and/or plate, (2) Crozon's syndrome, (3) Treacher-Collins syndrome, (4) Pierre-Robin syndrome, (5) hemi-facial atrophy, (6) hemi-facial hypertrophy, and (7) severe craniofacial deformities resulting in physically handicapping malocclusion.

Services Not Covered:

- Repair of damaged orthodontic appliances;
- Removable orthodontic retainer adjustment;
- Replacement of lost or missing appliance;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation and restoration for misalignment of teeth.

Additional Benefits:

The Plan will provide Benefits for services such as diagnostic consultations (D9310) and post-surgical services to treat complication due to unusual circumstances (D9930).

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

Exclusions:

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

The Plan does not cover the following:

- Covered Services and non-Covered Services provided by Non-Network Providers;
- TMJ services
- Viral culture
- Caries test
- Stains for microorganisms

- Electron microscopy
- Consultation on slides preparation
- Nutritional counseling
- Tobacco counseling
- Oral Hygiene Instruction
- Tissue conditioning
- Grafts
- Surgical replacement screw retained
- Sinus Augmentation
- Intraoral placement of a fixation device
- Gold Foil
- Coping
- Canal preparation
- Splinting
- Interim dentures (complete or partial)
- Fluoride Gel Carrier
- Provisional retainer Crown
- Missed or Cancelled appointment
- Non-intravenous conscious sedation
- Analgesia – Nitrous Oxide
- House/extended care call
- Case presentation
- Behavior Management
- Athletic mouth guard
- External bleaching
- Facial Moulage
- Prostheses (Nasal, Auricular, Orbital, Facial, Cranial)
- Feeding Aid
- Speech Aid
- Palatal Lift Prosthesis
- Radiation Carrier / Shield or Cone locator
- Surgical Splint
- Condylectomy
- Disc repair
- Skin graft
- Lefort I, II, or III
- Sialolithotomy
- Excision of salivary glad

Pediatric Vision Services

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

Covered Contact Lenses means elective contact lenses available from a selection of contact lenses. The Network Provider will show the Covered Person the selection of Covered Contact Lenses.

Covered Frames means the selection of frames covered by the Plan. The Network Provider will show the Covered Person the selection of Covered Frames.

Eye Examination means the comprehensive eye examination of an individual's complete visual system. An Eye Examination includes: case history, monocular and binocular visual acuity, with or without present corrective lenses; neurological integrity (pupil response); biomicroscopy (external exam); visual field testing (confrontation); ophthalmoscopy (internal exam); tonometry (intraocular pressure); refraction (with recorded visual acuity); extraocular muscle balance assessment; dilation as required; present prescription analysis; specific recommendation; assessment plan; and Provider signature.

Prescription Lenses means single vision lenses, bifocal lenses, trifocal lenses or lenticular lenses.

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

The Plan provides Benefits for the following pediatric vision services:

- **Eye exam:** Covered in full every Benefit Year. Includes dilation, if professionally indicated.
    - 92002/92004 New patient exams
    - 92012/92014 Established patient exams
    - S0620 Routine ophthalmologic exam w/refraction - new patient
    - S0621 Routine ophthalmologic exam w/refraction - established patient
- **Eyeglasses and Frames:** Covered in full every Benefit Year if you are diagnosed with a visual condition that:
    - Requires the use of eyeglasses;
    - Is within one (1) of the following categories:
        - Amblyopia;
        - Post surgical eye condition;
        - Diminished or subnormal vision; or
        - Other diagnosis which indicates the need for eyeglasses; and

- Requires a prescription correction in the stronger lens no weaker than:
  - +0.50, 0.50 sphere +0.50, or 0.50 cylinder;
  - 0.50 diopter of vertical prism; or
  - A total of (two) 2 diopter of lateral prism.

A Covered Person eligible for eyeglasses and frames according to the above guidelines shall be eligible for one (1) pair of eyeglasses and frames each Benefit Year except that such Covered Person shall also receive a maximum of one (1) replacement pair of eyeglasses each Benefit Year if the Covered Person's eyeglasses are broken or lost during the Benefit Year or the eyeglass prescription is changed during the Benefit Year.

Lenses:

- V2100-2199 Single Vision
- V2200-2299 Conventional (Lined) Bifocal
- V2300-2399 Conventional (Lined) Trifocal
- V2121, V2221, V2321 Lenticular
- Note: Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting if the prescription specifically indicates a diagnosis of photophobia. Lenses shall be polycarbonate and scratch coated with no additional Copayment.

Frame & Frame Fitting:

- V2020 Frame
- V92340 Fitting of spectacles, except for aphakia; monofocal
- V92341 Fitting of spectacles, except for aphakia; bifocal
- V92342 Fitting of spectacles, except for aphakia; multifocal, other than bifocal

Contact Lenses: Covered once every Benefit Year in lieu of eyeglasses at your election if:

- The corrected acuity in your stronger eye is 20/50 and shall be improved with the use of contact lenses;
- Your visual prescription is of + or – 8.00 diopter or greater; or
- Your diagnosis is 4.00 diopter anisometropia.

  - V2500-V2599 Contact Lenses. Note: In some instances, Network Providers may charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the Contact Lenses received is less than the allowance, you may submit a Claim for the remaining balance (the combined reimbursement will not exceed the total allowance). Pre-authorization is required for expenses in excess of $600 for Medically Necessary Contact Lenses.

Network Providers will obtain the necessary pre-authorization for these services.

Exclusions:

Although we may list a specific service as a Benefit, we will not cover it unless we determine it is Medically Necessary for the prevention, diagnosis, care or treatment of a covered condition.

The Plan does not cover the following:

- Covered Services and non-Covered Services provided by Non-Network Providers;
- Any vision service, treatment or materials not specifically listed as a Covered Service;
- Services and materials that are Experimental or Investigational;
- Services or materials which are rendered prior to your effective date;
- Services and materials incurred after the termination date of your coverage unless otherwise indicated;
- Services and materials not meeting accepted standards of optometric practice;
- Services and materials resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are strictly cosmetic in nature including charges for personalization or characterization of prosthetic appliances;
- Services or materials provided as a result of intentionally self-inflicted Sickness or Injury;
- Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
- State or territorial taxes on vision services performed;
- Medical treatment of eye disease or Sickness or Injury;
- Special lens designs or coatings other than those described in this EOC;
- Replacement of lost/stolen eyewear other than as described in this EOC;
- Non-prescription (Plano) lenses;
- Two pairs of eyeglasses in lieu of bifocals;
- Services not performed by licensed personnel;

- Prosthetic devices and services;
- Insurance of contact lenses;
- Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption.
- Tinting if not Medically Necessary;
- Photochromics if not Medically Necessary;
- Anti-reflective coatings if not Medically Necessary;
- Other lens options which are not Medically Necessary;
- Low vision services;
- A press-on prism.

This Evidence of Coverage and Health Insurance Contract ("EOC") constitutes a contract between you and CareSource for the CareSource Plan. This EOC takes the place of any other issued to you by CareSource on a prior date.

This EOC is delivered in and governed by the laws of the Commonwealth of Kentucky. All coverage under this Plan shall begin at 12:00 midnight and shall end at 11:59:59 Eastern Standard Time.



Pamela B. Morris
President and Chief Executive Officer
CareSource Kentucky Co.



CareSource.com/marketplace/KY

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