Marketplace Plan

Nevada

Evidence of Coverage

Plan Year 2027

CareSource is a
Qualified Health Plan Issuer in the
Silver State Health Insurance Exchange

CareSource Nevada Co.
6385 Rainbow Blvd Suite 500
Las Vegas, NV 89118

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 IMPORTANT THAT YOU READ YOUR POLICY. This policy is a legal contract between you and CareSource.

You may return this policy within ten (10) days and have a refund of the premium paid if you are not satisfied with the policy for any reason.

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Dear CareSource Member,

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

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

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

Thank you for choosing CareSource. We look forward to serving you and your health needs. If you have any questions or concerns about your health care or your coverage under the Plan, please call us at 1-833-230-2099.

Sincerely,

Erhardt H. Preitauer

President and Chief Executive Officer

CareSource Nevada Co.

SECTION 1 – INTRODUCTION

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

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

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

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

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

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

CareSource Contact Information:

Member Services: 833-230-2099
24-Hour Nurse Advice Line: 833-687-7378
Online: CareSource.com/marketplace
Address: P.O. Box 8730 Dayton, OH 45401 ATTN: Member Services

How to Use Your Evidence of Coverage

- Read the entire EOC. Then keep it in a safe place for future reference.
- Many of the sections of this EOC are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your EOC and any Riders/Enhancements or Amendments at CareSource.com/marketplace or request printed copies by contacting Member Services.
- CareSource will mail a written copy of your EOC within seven (7) business days of your request.
- Capitalized words in this EOC have special meanings and are defined in Section 2: *Definitions*.

Because this EOC is a legal document, we encourage you to read it and any of its attached Riders/Enhancements and/or Amendments carefully. You are responsible for understanding all provisions of this document, including any Riders/Enhancements or Amendments. Many of the sections of this EOC relate to one another and you may need to read multiple sections to get all of the information you need. When reviewing your EOC, you should read the entire document and pay particular attention to Section 5: *Your Covered Services,* Section 6: *Prescription Drugs,* and Section 7: *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 other documentation provided to you by the Plan. Please be aware that your Providers do not have a copy of this EOC, and they are not responsible for knowing or communicating your Benefits.

Defined Terms

Because this EOC is part of a legal document, it is important that you understand the information it contains. Certain capitalized words within this EOC have special meanings that are defined in Section 2: *Definitions*. You should refer to Section 2 often as you see capitalized terms in order to have a clearer understanding of your EOC. When we use the words "we," "us," and "our" in this document, we are referring to CareSource. When we use the words "you" and "your" in this EOC, we are referring to you as a Covered Person, or the Responsible Party, as these terms are defined in Section 2: *Definitions*.

Your Responsibilities

Be Enrolled and Pay Required Premiums

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

Choose Your Health Care Providers

It is your responsibility to select the Network Providers and Network Pharmacies that will provide your health care. We can assist you to find Network Providers and Network Pharmacies. We will not cover

Health Care Services provided by a Non-Network Provider except as described in this EOC. For more information on choosing your Network Providers, please see Section 3: *How the Plan Works, Choose a PCP.*

Your Financial Responsibility

You must pay Copayments, Coinsurance, and the Annual Deductible for many Covered Services. See Section 3: *How the Plan Works* and the Schedule of Benefits for further detail on your Copayments, Coinsurance, and Annual Deductible obligations. The exact amount of the Copayments, Coinsurance, and Annual Deductible for which you are responsible is listed in the Schedule of Benefits.

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: 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 7: *What Is Not Covered* to become familiar with the Plan's limitations and Exclusions.

Show Your ID Card

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

Don't Forget Your ID Card

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

The Marketplace

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

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

Information regarding enrollment options is available from the Marketplace at nevadahealthlink.com. Additional information on how to enroll in a plan is available at CareSource.com/marketplace.

Eligibility Requirements

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

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

If you are seeking coverage outside of the Marketplace, you and your Dependents must meet all of the Plan's eligibility requirements. Generally, you will qualify if you are a resident of Nevada and reside within the Plan's Service Area.

CareSource or the Marketplace may ask for verification that you are eligible for coverage under the Plan. You must show proof that you meet and continue to meet the conditions above. Coverage under this Plan is available to you no matter what your health condition is.

Dependents who are eligible to participate in the Plan include:

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

Dependent Provisions

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

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

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

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

The Plan will provide Benefits to your Dependent child for whom you have legal custody or guardianship. 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 us, 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 3: *How the Plan Works, Grace Period*, if payment of Premium is not received within sixty (60) days as described above, you will be responsible for the cost of any Health Care Services received on or after the thirty-second (32nd) day of the birth, adoption or the award of legal custody or guardianship for a child, as the case may be.

We will not deny enrollment to your child on the basis that the child was born out of wedlock; that the child is not claimed as a Dependent on your federal tax return; or that the child does not reside in your household or within the Plan's Service Area. If you are required by a court or administrative order to provide health care coverage for your Dependent child and you do not make application to obtain coverage for the child, we will enroll your Dependent child as a Dependent under the Plan upon an application from the other parent or pursuant to a child support order as required by state law and consistent with any applicable Marketplace or Plan rules or processes. We will not terminate such child's coverage unless we receive satisfactory written evidence that either the court or administrative order is no longer in effect or the child is or will be enrolled under comparable health care coverage provided by another health insurer, and such coverage will take effect not later than the effective date of termination of this Plan. Please see Section 10: *Coordination of Benefits* for additional information.

Application and Enrollment for CareSource Coverage

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

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

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

Confirmation of Eligibility

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

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

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

Annual Eligibility Determinations

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

Enrollment Date

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

Ineligibility and Your Right to Appeal Eligibility Decisions

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

If you or your Dependent seek coverage directly through us (and not the Marketplace) and we determine that you or your Dependent is not eligible for the Plan, we will notify you. You have the right to appeal such decision if you disagree. Your appeal rights are described in Section 9: *Complaint Process, Claims Procedures, and Adverse Benefit Determination Appeals.*

Availability of Benefits After Enrollment in the Plan

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

Change in Eligibility Status or Personal Information

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

- You become pregnant.
- You have a baby.
- Your address or phone number changes.
- Your immigration status changes.
- Your income changes.
- Your marital status changes.
- A Dependent reaches the limiting age.
- You or anyone on the policy becomes entitled to Medicare Part A or enrolls in Medicare Part B.
- You receive health insurance coverage through another payor, be it employment-based coverage or other coverage.

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

A Covered Person's coverage under the Plan terminates on the date such person ceases to be eligible for coverage. Failure to notify the Marketplace or us of any person no longer eligible for coverage will not

obligate us to provide such coverage. Acceptance of payments for persons no longer eligible for coverage will not obligate us to pay for Health Care Services.

Open Enrollment

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

Special Enrollment

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

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

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

- Loss of minimum essential coverage due to circumstances such as: loss of a job, voluntarily quitting a job, divorce or legal separation, no longer residing in your plan's service area, no longer a Dependent, and loss of coverage under parent's plan among other circumstances. Loss of minimum essential coverage must be reported 60 days prior to or after loss, enrollment will be effective on the first day of the following month. We retain the right to reject the enrollment if member does not make their premium payment.
- Enrollment in any non-calendar year group health plan or individual health insurance coverage. Coverage will begin on the 1st day of the month following loss of prior coverage if plan is selected 60 days before expiration.
- Loss of pregnancy related coverage or loss of pregnancy related services provided through the Children's Health Insurance Program "unborn child" option.
- Loss of Medicaid coverage.
- Gaining or becoming a Dependent due to marriage, birth, adoption or placement for adoption, placement in foster care, or through child support order or other court order. Coverage must be reported 60 days after event date, enrollment will be effective on the first day of the following month or on the DOB in the case of a birth. In the case of a new spouse or domestic partner they may only enroll if at least one partner had minimum essential coverage or lived in a foreign country or in a U.S. territory at least 1 day during the preceding 60 days before marriage.
- Enrollment or non-enrollment in a Qualified Health Plan or other health plan that was unintentional, inadvertent, or erroneous and is the result of an error, misrepresentation, misconduct or inaction of the Marketplace or other entity providing enrollment assistance or conducting enrollment services.
- A Qualified Health Plan or other health plan violates a material provision of its contract with you.
- Gaining access to new Qualified Health Plans or other health plan as a result of a permanent move. Coverage must be reported 60 days after event date, enrollment will be effective on the first day of the following month if selected by the 15th of the month. Must provide evidence that the member had coverage during the previous 60 days.

- Victim of domestic abuse or spousal abandonment or is a Dependent of a victim of domestic abuse or spousal abandonment.
- Being determined ineligible for Medicaid or the Children's Health Insurance Program.
- Gaining a new immigration status as a citizen, national, or lawfully present. Coverage must be reported 60 days after event date, enrollment will be effective on the first day of the following month if selected by the 15th.
- Gaining access to an individual Health Reimbursement Arrangement (HRA), or is newly provided a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).
- A Qualified Health Plan is decertified by the Department of Insurance and no longer can provide coverage to you or your Dependent.
- Loss of a Dependent on the plan through divorce or legal separation.
- Your death or the death of a Dependent.

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

- Release from incarceration.
- Newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or a change in eligibility for cost-sharing reductions.
- An individual gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603), may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one (1) time per month or an individual is or becomes a Dependent of an Indian, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one (1) time per month at the same time as the Indian.
- An individual or their Dependents demonstrates to the Marketplace, that the individual meets other exceptional circumstances as the Marketplace may provide.
- An individual or their Dependents demonstrates to the Marketplace that a material error related to plan benefits, service area, or premium influenced individual to purchase a Qualified Health Plan through the Marketplace.
- At the option of the Marketplace, an individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a Qualified Health Plan through the Marketplace following termination of Marketplace enrollment due to a failure to verify such status within the specified time period or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for the Marketplace to verify his or her citizenship, status as a national, or lawful presence.

Non-Marketplace Enrollment

You can also enroll in a health insurance plan for you and your family through the Silver State Health Insurance Exchange (Nevada's state-based health insurance exchange). The Silver State Health Insurance Exchange (referred to as the Marketplace in this EOC) allows you to get quotes from different insurance companies that are available on the Exchange. You can compare different plans, get quotes and find out if you qualify for financial assistance. The Silver State Health Insurance Exchange is the only way to receive financial assistance for your health insurance. You can enroll online by visiting nevadahealthlink.com or by calling 1-800-547-2927 TTY 711.

SECTION 2 – DEFINITIONS

What this section includes:

- Definitions of terms used throughout this EOC.

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

Active Course of Treatment means any of the following:

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

Adverse Benefit Determination means a determination by CareSource that an admission, availability of care, continued stay or other Health Care Service that is a covered Benefit has been reviewed and, based upon the information provided, does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

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 Medical Services, Urgent Care Services, pre-scheduled rehabilitative, laboratory, or Diagnostic Services. An Alternate Facility may also provide Behavioral Health Care Services on an Outpatient, intermediate or Inpatient basis.

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

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

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

CareSource at all times reserves the right to make Amendments.

Annual Deductible or Deductible means the amount you must pay for Covered Services in a Benefit Year before we will begin paying for Benefits in that Benefit Year. Copayments do not count towards the Annual Deductible. Network Benefits for Preventive Health Care Services are never subject to payment of the Annual Deductible.

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

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

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

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

- Any charges for Non-Covered Services;
- Charges that exceed Eligible Expenses;
- Copayments and Coinsurance amounts for Covered Services available by an optional Rider/Enhancement, unless specifically stated otherwise in the Rider/Enhancement; and
- The amount of any reduced Benefits if you do not obtain authorization from us when required to do so under the terms of the Plan.

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

Authorized Representative means an individual who represents a Covered Person in an Internal Appeal or External Review process of an Adverse Benefit Determination and who is any one of the following:

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

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

Basic Health Care Services means Essential Health Benefits.

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

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

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

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

Binder Payment means the amount required to become eligible for Benefits, which includes your first month(s) of Premium as well as any unpaid Premiums from previous enrollments within the preceding 12-month period.

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

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

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

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

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

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

Clinical Trial means a Clinical Trial that (i) is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial, as set forth in FDA regulations, that is conducted in relation to the prevention of cancer or another life-threatening disease or condition (defined as any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted) or phase II, III, or IV for treatment of chronic fatigue syndrome; and (ii) meets all of the following criteria:

- The purpose of the trial is to test whether the intervention potentially improves your health or the treatment is given with the intention of improving your health, and is not designed simply to test

toxicity or disease pathophysiology;

- The trial does one of the following:
  - Tests how to administer a Health Care Service for the treatment of cancer or a life-threatening disease;
  - Tests responses to a Health Care Service for the treatment of cancer or a life threatening disease;
  - Compares the effectiveness of Health Care Services for the treatment of cancer or a life-threatening disease; or
  - Studies new uses of Health Care Services for the treatment of cancer or a life- threatening disease; and
- The trial is approved by one of the following:
  - The National Institutes of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services;
  - The Centers for Disease Control and Prevention, or one of its cooperative groups or centers;
  - The Agency for Health Care Research and Quality, or one of its cooperative groups or centers;
  - The Centers for Medicare and Medicaid Services, or one of its cooperative groups or centers;
  - The United States Food and Drug Administration;
  - The United States Department of Defense; or
  - The United States Department of Veteran's Affairs.

Coinsurance means the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Services after the Annual Deductible is satisfied and until you reach your Out-of-Pocket Maximum. See Section 3: *How The Plan Works* for additional detail.

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

Copayment means the charge, stated as a flat dollar amount, that you are required to pay for certain Covered Services. See Section 3: *How The Plan Works* for additional detail.

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

Covered in Full means that the Covered Service is provided to the Member at no cost to the Member if provided by a Network Provider and provisions contained within this Evidence of Coverage are adhered to.

Covered Person means an individual, including you or your Dependent, who is properly enrolled by the Marketplace and/or CareSource, as the case may be, and due to such enrollment is entitled to receive Benefits provided under this Plan. Often, a Covered Person is referred to as “you.”

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

recognized by the relevant medical specialty community. "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

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

Day Hospital means a Facility that provides day rehabilitation services on an Outpatient basis.

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

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

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

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

Effectuated or Effectuation means paying your Premium and/or enrolling in the Plan in accordance with Marketplace standards, state law, or Plan guidelines/rules, as applicable, in order to allow the Benefits, terms, conditions, limitations, and Exclusions under this Evidence of Coverage to take effect.

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

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

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We

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

Emergency Health Care Services means Emergency Medical Services provided in a Hospital Emergency Room or an independent freestanding emergency department.

Emergency Medical Condition or Emergency means a medical condition that manifests itself by signs and symptoms of sufficient severity or acuity, including severe pain, such that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in:

- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part; or
- In the case of a pregnant woman who is having contractions:
  - A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or
  - A situation in which Transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of Emergencies include, but are not limited to, a heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures, and convulsions.

Emergency Medical Services means Health Care Services necessary for the treatment of an Emergency, including (i) a medical screening examination, as required by federal law, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition, or (ii) such further medical examination and treatment that are required by federal law to Stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

Emergency Room means the section, department or Facility of a Hospital that either: (1) is licensed by the state as an Emergency Room; (2) held out to the public as providing treatment for Emergency Medical Conditions; or (3) on one-third of the visits to the department in the preceding calendar year actually provided treatment for Emergency Medical Conditions on an urgent basis.

Essential Health Benefits means ambulatory patient services, Emergency Health Care Services, Inpatient Services, Maternity and newborn care, 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 state.

Exclusions, Exclusion or Excluded means Health Care Services that are not Covered Services under the terms of the Plan.

Experimental or Investigational Services or Experimental or Investigational means medical, surgical, diagnostic, psychiatric, Substance Use Disorders Treatment or other Health Care Services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination

regarding coverage in a particular case, are determined to be any of the following: not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; subject to review and approval by any institutional review board for the proposed use; the subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight (this includes diagnostic testing for purposes of possible inclusion in a Clinical Trial); or any service billed with a temporary procedure code. Devices that are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.

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

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

Generic Drug means a Prescription Drug that is either:

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

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

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

Habilitative Services or Habilitative means those Health Care Services that help a person keep, learn or improve skills and functioning for daily living. An example of Habilitative Services includes therapy for a child who is not walking or talking at the expected age. These Habilitative Services may include physical

and occupational therapy, speech therapy or speech pathology services, and other Health Care Services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

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

Hearing Aid List means the list of approved hearing aids covered by the Plan as Covered Services under the TruHearing® Choice Program, which provides Covered Persons with access to hearing aids at discounted rates. This list of approved hearing aids is subject to periodic review and modification (generally quarterly, but no more than four (4) times per Benefit Year).

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

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

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

HSA Eligible Plan means the plan meets the state, federal, and IRS requirements to be considered a high Deductible health plan allowing the Member to leverage the benefits of a health savings account. CareSource plans with the term "HSA Eligible" in the plan name meet this definition.

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

Infertility means the inability after 12 consecutive months of unsuccessful attempts to conceive a child despite regular exposure of female reproductive organs to viable sperm.

Injury means bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient means relating to a patient who has been admitted to a Hospital, Skilled Nursing Facility, Inpatient hospice, long term acute care, respite care, or Inpatient Rehabilitation Facility.

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

Inpatient Rehabilitation Facility means a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation Health Care Services (*e.g.*, physical therapy, occupational therapy and/or speech therapy) on an Inpatient basis, as authorized by law.

Inpatient Stay means an uninterrupted confinement following formal admission to a Hospital, Skilled Nursing Facility, Inpatient hospice, long term acute care, respite care, or Inpatient Rehabilitation Facility.

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 Nevada.

Marketplace means the health insurance benefit exchange established by the Affordable Care Act for the State of Nevada. The Silver State Health Insurance Exchange is Nevada's state-based health insurance exchange.

Maternity Services means Health Care Services provided in relation to Pregnancy and delivery of a newborn child. Maternity Services include care during labor, birthing, prenatal care, and postpartum care.

Maximum Allowable Amount means the maximum amount that the Plan will allow and provide Benefits for Covered Services you receive.

Medically Necessary/Medical Necessity means Health Care Services that are determined to be medically appropriate in accordance with CareSource's medical policies and nationally recognized guidelines; are not Experimental, Investigational, or Unproven 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 Institute 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.

Medication Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of Substance Use Disorders. Medications used in MAT are approved by the Food and Drug Administration (FDA) and MAT programs are clinically driven and tailored to meet each patient's needs. MAT Medications are administered, dispensed, and prescribed in various settings such as a SAMHSA-accredited and certified Opioid Treatment Program (OTP) or certified practitioners depending on the medication.

Member has the same meaning as Covered Person.

Member Services means the part of CareSource devoted to answering questions and assisting Members with finding and using the Benefits and services offered by CareSource.

Network means the group of Providers who have agreed with the Plan to provide Health Care Services to Covered Persons at a contracted rate.

Network Benefits, for Physician Health Care Services, are Benefits for Covered Services that are provided by or under the direction of a Physician who is a Network Provider in his or her office or at a Facility that is a Network Provider. For Facility services, these are Benefits for Covered Services that are provided at a Facility that is a Network Provider by a Physician who is a Network Provider or other Network Provider. Network Benefits include Emergency Medical Services.

Network Provider means a Provider who has entered into a contractual arrangement with us or is being used by us, or another organization that has an agreement with us, to provide certain Covered Services or certain administration functions for the Network associated with this EOC. A Network Provider may also be a Non-Network Provider for other Health Care Services or products that are not covered by the contractual arrangement with us as Covered Services. In order for a Pharmacy to be a Network Provider, it must have entered into an agreement with the PBM to dispense Prescription Drugs to Covered Persons, agreed to accept specified reimbursement rates for Prescription Drugs, and been designated by the PBM as a Network Pharmacy.

Non-Covered Services means those Health Care Services that are not Covered Services under this EOC.

Non-Network Provider means a Provider who is not in the Plan's Network.

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

Opioid Analgesic means a controlled substance that has analgesic pharmacologic activity at the opioid receptors of the central nervous system, including the following drugs and their varying salt forms or chemical congeners: buprenorphine, butorphanol, codeine (including acetaminophen and other combination products), dihydrocodeine, fentanyl, hydrocodone (including acetaminophen combination products), hydromorphone, meperidine, methadone, morphine sulfate, oxycodone (including acetaminophen, aspirin, and other combination products), oxymorphone, tapentadol, and tramadol.

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

Out-of-Pocket Maximum means the maximum amount you must pay before CareSource begins to pay 100% of the allowed amount. This limit does not include Premium Payments, Balance- Billed charges or the cost of Health Care Services not covered by the Plan.

Outpatient means relating to a patient who has not been admitted to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility.

Outpatient Services means Health Care Services other than Inpatient Services.

PCP means Primary Care Provider, which is a Network Physician, Network Physician group practice, advanced practice nurse, or advanced practice nurse group practice trained in family medicine (general practice), internal medicine, or pediatrics that you select to be responsible for providing or coordinating all Covered Services for Network Benefits.

Pharmacy means an establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

Pharmacy and Therapeutics Committee means the committee that CareSource (or CareSource's PBM) designates for, among other things, classifying Prescription Drugs into specific tiers on the Prescription Drug Formulary. For more information about what the Pharmacy and Therapeutics Committee does, see Section 6: *Prescription Drugs*.

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

Physician means any Doctor of Medicine, "M.D.," or Doctor of Osteopathy, "D.O.," who is properly licensed and qualified by law.

Plan means the CareSource Marketplace Plan.

Pregnancy includes all of the following: prenatal care; postnatal care; childbirth; and any complications associated with Pregnancy.

Premium means the periodic fee required for each Covered Person, in accordance with the terms of the Plan.

Prescription Drug means a medication, product, or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, only be dispensed using a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs include:

- Immunizations administered in a Pharmacy
- Inhalers (with spacers);
- Insulin;
- And the following diabetic supplies:
    - Insulin syringes and needles

- Blood glucose testing strips and meters
- Urine glucose testing strips
- Ketone testing strips and tablets
- Lancets and lancet devices
- Continuous glucose monitors

Prescription Drug Cost means the rate the PBM has agreed to pay its Pharmacies that are Network Providers, including a dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Pharmacy that is a Network Provider.

Prescription Drug Formulary means a list that categorizes commonly used medications, products or devices that have been approved by the U.S. Food and Drug Administration into tiers. This list is subject to periodic review and modification (generally quarterly). You may determine to which tier a particular Prescription Drug has been assigned by contacting Member Services at the toll-free number on your ID Card or by using the Price a Medication Tool on the Find My Prescriptions page on CareSource.com.

Preventive Health Care Services means routine or screening Health Care Services that are designated to keep you in good health and to prevent unnecessary Injury, Sickness, or disability, including but not limited to the following as may be appropriate based on your age and/or gender: Evidence-based items or Health Care Services with an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF); immunizations for routine use in children, adolescents, and adults with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-informed preventive care screenings for infants, children, and adolescents provided in guidelines supported by the Health Resources and Services Administration (HRSA); and evidence-informed preventive care and screening for women provided in guidelines supported by HRSA and not otherwise addressed by the USPSTF. The complete list of recommendations and guidelines can be found at: HealthCare.gov/center/regulations/prevention.html and the other websites listed under Section 5: *Your Covered Services, Preventive Health Care Services* (collectively, the "List"). The List will be continually updated to reflect both new recommendations and guidelines and revised or removed guidelines.

Prior Authorization means any practice implemented by us in which Benefits for a Health Care Service is dependent upon a Covered Person or a Provider obtaining approval from us prior to the Health Care Service being performed, received, or dispensed, as applicable. This includes prospective or utilization review procedures conducted prior to providing a Health Care Service.

Provider means a duly licensed person, Pharmacy, or Facility that provides Health Care Services within the scope of an applicable license and is a person, Pharmacy, or Facility that 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. If you have a question about a Provider, please call the number on the back of your ID Card.

Qualified Health Plan means a health plan offering on the Marketplace that satisfies the requirements set forth under the Affordable Care Act at 42 U.S.C. § 18021(a)(1).

Recognized Amount means the amount or value for an item or service furnished by a Non-Network Provider when rendering services for Emergency Care or while at an in-network facility where you've either not provided informed consent or for certain ancillary services. This will be used to determine the Member cost-share obligation.

Record means any written, printed, or electronically recorded material maintained by a Provider in the course of providing Health Care Services to a patient concerning the patient and the services provided. Record also includes the substance of any communication made by a patient to a provider in confidence during or in connection with the provision of Health Care Services to a patient or information otherwise acquired by the Provider about a patient in confidence and in connection with the provision of Health Care Services to a patient.

Regular Basis means you have received Health Care Services in the last twelve (12) months from a PCP or Provider.

Rescission means a cancellation of coverage that has retroactive effect. Rescission is allowed if it is due to Fraud or intentional misrepresentation of a material fact. See Section 11: *When Coverage Ends, Rescission* for more information.

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

Responsible Party means the person responsible for payment of Premiums, Copayments, Coinsurance and Deductibles.

Retail Health Clinic means a Facility that provides limited basic medical care services to Covered Persons on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores and may also be referred to as a Convenience Care Clinic.

Rider/Enhancement means any attached written description of additional Covered Services not described in Sections 1 through 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. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Sickness means physical sickness, disease or Pregnancy. The term Sickness as used in this EOC does not include Behavioral Health Disorders or Substance Use Disorders, regardless of the cause or origin of the Behavioral Health Disorder or Substance Use Disorder.

Skilled Nursing Facility means a Hospital or nursing Facility that is licensed and operated as required by law.

Specialist means a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Stabilize means, with respect to an Emergency Medical Condition, that no material deterioration of a Covered Person's medical condition is likely, within reasonable probability, to result from or occur during the Transfer from a Facility. With respect to an Emergency Medical Condition of a pregnant woman who is having contractions, that the woman has delivered (including placenta).

Substance Use Disorder means those alcoholism and Substance Use Disorders that are listed in the current *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association).

Substance Use Disorders Treatment means Health Care Services for the diagnosis and treatment of Substance Use Disorders. Substance Use Disorders Treatment includes Health Care Services for the prevention, treatment, and rehabilitation of Covered Persons who abuse alcohol or other drugs.

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

Telehealth Services means the use of synchronous or asynchronous telecommunications technology or audio only telephone calls by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration.

Terminal Condition means an irreversible, incurable, and untreatable condition that is caused by disease, illness, or injury and will likely result in death. A Terminal Condition is one in which there can be no recovery, although there may be periods of remission.

Terminal Illness means a medical condition for which a Covered Person has a medical prognosis that his or her life expectancy is six (6) months or less if the condition runs its normal course, as certified by the Covered Person's Physician.

Therapeutic Abortion means an abortion performed to save the life or prevent substantial and irreversible impairment of a major bodily function of the mother, or as a result of incest or rape.

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

Third Party means any individual, automobile insurance company, or public or private entity against which a Covered Person or the Covered Person's estate has a Tort Action.

Tort Action means a civil action for Injury, death, or loss to a Covered Person. "Tort Action" includes any claim for damages for Injury, death, or loss to person, whether or not a lawsuit is pending, or a Claim in connection with uninsured or underinsured motorist coverage, but does not include a civil action for breach of contract or another agreement between persons.

Transfer means the movement (including the discharge) outside a Hospital's Facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with the Hospital), but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the Facility without the permission of any such person.

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

United States means the country commonly called the United States (US or U.S.) or America, consisting of fifty (50) states and the Federal District of Washington D.C.

Unproven Service or Unproven means Health Care Services, including medications that are not consistent with conclusions of prevailing medical research, that demonstrate that the service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs: (a) well-conducted randomized controlled trials (two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received) or (b) well-conducted cohort studies (patients who receive study treatment are compared to a group of patients who receive standard therapy and the comparison group must be nearly identical to the study treatment group.) Decisions about whether to cover new technologies, procedures, and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one (1) year of the request for treatment) we may determine that an Unproven Service meets the definition of a Covered Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Services means those Health Care Services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay, but that does not pose a threat to the life, limb, or permanent health of the Covered Person, and may include such Health Care Services provided by Non-Network Providers.

Utilization Management means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the plan. The system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures, and retrospective review.

SECTION 3 – HOW THE PLAN WORKS

This section included information on:

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

Benefits

The Service Area

Please visit our website for a map of the Plan's Service Area. The Plan is available to you if you live in the Service Area. If you plan to move out of the Service Area, please contact Member Services.

Out of Service Area Dependent Child Coverage

Benefits for Covered Services for enrolled Dependent children who reside outside the Service Area are payable at the Network level and are limited to the Maximum Allowable Amount. Payment is subject to any Coinsurance, Copayment and/or Deductible. You may be responsible for any amount in excess of the Maximum Allowable Amount. As restricted for all Members, coverage for services outside of the Service Area is limited to Network Providers with the exception of Emergency Medical Services, including Emergency Ambulance Services, and Urgent Care Services.

Network Providers

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

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

Looking for a Network Provider?

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

Note: It is important you receive Health Care Services from Network Providers because Health Care Services you receive from Non-Network Providers are generally not reimbursable or covered by the Plan and the Non-Network Provider may bill you directly for the entire amount of any Health Care Services

received, except as otherwise provided in this section.

Covered Services From Network Providers

The Plan provides Benefits when you receive Covered Services from Network Providers. In order to receive Benefits for Covered Services, you must choose a Network Provider to provide your Health Care Services, with exception to the services as explained in this section, elsewhere in this Evidence of Coverage, and as required by law.

Services Provided by Non-Network Providers

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

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

- You receive Emergency Medical Services
- You receive Emergency Ambulance Services;
- You receive Urgent Care Services while you are temporarily outside the Service Area;
- You receive Health Care Services from a Non-Network Provider (such as an anesthesiologist, pathologist, Emergency Room Physician, consulting Physician, or radiologist) while you are in a Hospital or other Facility that is a Network Provider; or
- There is a specific situation involving the continuity of your health care, as explained below in this Section 3;
- The Health Care Services you need are Covered Services under the Plan and not available from a Network Provider or Facility. In this case, you, your PCP or Non-Network Provider must obtain our Prior Authorization.

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

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

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

- You or the Non-Network Provider will need to obtain a Prior Authorization for non-network provided services in a network facility; however, you will not need a Prior Authorization for Emergency Health Care Services or Emergency Ambulance Services;

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

What You Must Pay

Premium Payments

Your monthly payment may be paid online at CareSource.com/MPpay, by calling 833-230-2099, or mailing to CareSource at P.O. Box 632631 Cincinnati, OH 45263. We will provide you with other important information about Premium payments. You can also find this information on our website. You will receive a monthly bill for your Premium. Your payment is due by the date stated on the bill. You must pay your Premium when it is due in order for your Benefits to continue. You will not receive Benefits for Covered Services if we do not receive your Premium payments. We will also accept certain third-party payments in accordance with 45 C.F.R. § 156.1250.

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

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

Grace Period

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

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

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

of the Grace Period.

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

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

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

- Paying the Premium amount due in full before the Grace Period expires. When this occurs:
  - We will process all non-Prescription Drug Claims that were held;
  - We will notify Network Providers and the United States Department of Health and Human Services, where appropriate, that you are no longer in the Grace Period;
  - We recommend you contact your Pharmacy to have your Prescription Drug Claims reprocessed.
- Expiration of the Grace Period without paying the Premium amount due in full. When this occurs:
  - We will terminate your coverage back to the end of the first month of the Grace Period if you are receiving APTC and to the end of the last month paid for those not receiving APTC.
  - We will deny any claims held during the Grace Period;
  - We will notify Network Providers and the United States Department of Health and Human Services, where appropriate, that you are no longer in the Grace Period;
  - See Section 11*: When Coverage Ends* for further details.

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

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

Annual Deductible

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

Eligible Expenses

Eligible Expenses, generally, are charges for Covered Services (*see* the full definition in Section 2: *Definitions*). For certain Covered Services, we will not pay Eligible Expenses until you have met your Annual Deductible for that Benefit Year.

Coinsurance

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

Coinsurance - Example

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

Copayment

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

Annual Out-of-Pocket Maximum

The Annual Out-of-Pocket Maximum is the maximum amount that you will pay each Benefit Year for most Covered Services. For a complete definition of Annual Out-of-Pocket Maximum, see Section 2*: Definitions*. After you have met your Annual Out-of-Pocket Maximum for a Benefit Year, we will pay 100% of Eligible Expenses for Covered Services applicable to the Annual Out-of-Pocket Maximum through the end of that Benefit Year. For family coverage, each individual covered member within your family is contributing toward the family Annual Out-of-Pocket Maximum. However, for each individual covered member within your family, the maximum amount each member would pay toward the family Annual Out-of- Pocket Maximum is the individual Out-of-Pocket Maximum. The table below shows what does and does not apply toward your Annual Out-of-Pocket Maximum:

Plan Features	Applies to the Annual Out-of-Pocket Maximum?
Copayments	Yes
Payments Toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for Non-Covered Services	No
Adult Vision Benefits, if applicable	No
Premium Payments	No
Balance Billed Charges	No

If You Receive a Bill From a Network Provider

With the exception of a Copayment, Coinsurance, or Deductible amount, Network Providers may not bill you for Covered Services. However, Network Providers are permitted to bill you for Non- Covered Services. Please refer to Section 9: *Complaint Process, Claims Procedures and Adverse Benefit Determination Appeals* if you believe you received a bill that you should not have received.

Note: Please refer to Section 3: *How the Plan Works, Services Provided by Non-Network Providers* for more information on when Non-Network Providers may bill you for Health Care Services you receive, regardless of whether they are Covered Services or Non-Covered Services under the Plan.

The Plan Does Not Pay for All Health Care Services

Benefits are limited to Covered Services. For a definition of Covered Services, see Section 2: *Definitions*. Not all Health Care Services will be covered by the Plan.

Your Primary Care Provider

Choose a PCP

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

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

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

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

Visit Your PCP

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

Changing Your PCP

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

Please see *Section 3: How the Plan Works, Continuity of Care* for more information on how to obtain Covered Services from Providers who leave the Network.

If You Can'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, leave a message with the office staff or answering service. You should wait a reasonable amount of time for someone to call you back unless you need Emergency Health Care Services. You do not need to call your PCP before seeking Emergency Health Care Services. If you are unable to reach your PCP or the covering Provider, call Member Services during Business Hours or our 24-Hour Nurse Advice Line after or before Business Hours.

Canceling Provider Appointments

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

When You Need Specialty Care

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

Note: We do not require that you receive a referral before receiving Covered Services from a Network Specialist. The Plan allows you direct access to all Network Specialists. However, before you visit a Network Specialist, we recommend that you check with your PCP or Network Specialist to make sure that you, your PCP or Network Specialist have obtained any required Prior Authorization from us.

Providers Who Leave the Network

If your PCP or a Provider who you see on a Regular Basis tells us that he or she is moving away, retiring, or leaving the Network for any reason, we will use good faith efforts 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. 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 one hundred and twenty (120) 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 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 one hundred and twenty (120) 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 we will calculate any Copayments, Coinsurance or Deductibles at the in-Network rates. However, if you have successfully transitioned to a Network Provider, met or exceeded the Benefit limits under the Plan, or if the treatment is not Medically Necessary, then we may not authorize continuing coverage with that PCP or Provider who you have seen on a Regular Basis. Your PCP or Provider should contact the Utilization Management Department to obtain our Prior Authorization.

If you are pregnant and the Network Provider you are seeing in connection with your Pregnancy leaves the Network (for reasons other than Fraud or quality of care), you may, with our Prior Authorization, continue to receive Covered Services from that Provider for 120 days if you are in an Active Course of Treatment or for 90 days after delivery if you are pregnant. Please have your Provider contact the Utilization Management Department to obtain our Prior Authorization.

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

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

Continuity of Care for New Covered Persons

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

- For up to thirty (30) days after your coverage effective date if:
  - The Physician or nurse practitioner does not participate in another Marketplace Qualified Health Plan for which you are eligible through the Marketplace; or
  - The Physician or nurse practitioner is providing you with an Active Course of Treatment or is your PCP.
- Through the postpartum period if you are a new Covered Person and pregnant.
- Until death, if you are a new Covered Person with a Terminal Illness.

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

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

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

- Accept payment from the Plan at the rates we pay to Network Providers of the same specialty or sub-specialty;
- Accept such payment as payment in full and not charge you any more than you would have paid if the Provider was a Network Provider;
- Comply with the Plan's quality assurance standards;

- Provide us with necessary medical information related to the care provided; and
- Comply with our policies and procedures including procedures regarding referrals, obtaining Prior Authorization, and providing Covered Services pursuant to a treatment, approved by the Plan.

Prior Authorization

Prior Authorization is the process used by us to determine whether those Health Care Services listed on our Prior Authorization list meet evidence based criteria for Medical Necessity and are Covered Services under your Plan prior to the Health Care Service being provided. It is the responsibility of your Network Provider to obtain Prior Authorization. If you receive Health Care Services from a Non-Network Provider, you or the Non-Network Provider are responsible for obtaining Prior Authorization for the Health Care Services described on the Prior Authorization list. Please check with your Provider to ensure that your Provider has obtained Prior Authorization prior to you receiving any Health Care Services listed on the Prior Authorization list. The Prior Authorization list is available by calling Member Services at 1-833-230-2099 or by viewing it on our website at CareSource.com/mp-NV-pa. The Prior Authorization list is subject to change. Your Network Provider and you will be provided sixty (60) calendar days prior notice before a change is made to the Prior Authorization list.

If your Network Provider fails to obtain Prior Authorization from us for Health Care Services as required by us and such Provider renders such Health Care Services to you, the Network Provider shall be responsible for the costs of such Health Care Services and neither the Plan nor you will be required to pay for such Health Care Services. For Health Care Services provided by a Non-Network Provider, if Prior Authorization is not obtained by you or the Non-Network Provider, you are responsible for making full payment to the Non-Network Provider.

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

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

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

Benefit Determinations

In processing Claims, we review requests to determine whether the requested Benefits are Covered Services. This process is described below. If you have any questions regarding the information contained in this section, you may call Member Services at 1-833-230-2099.

Most Network Providers know which services require Prior Authorization and should obtain any required Prior Authorization. The ordering Network Provider will contact us to request Prior Authorization. We will work directly with your Network Provider regarding such Prior Authorization requests.

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

periodically.

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

Types of requests for Prior Authorization and Retrospective Medical Review:

Urgent Review Request - A request for review of any Prior Authorization determination for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (1) could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, (2) could seriously jeopardize the life, health, or safety of the member or others due to the member's psychological state, (3) in the opinion of a Physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care of treatment that is subject of the review, or (4) in the opinion of a Physician with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is subject of the review. In addition, a request involving Urgent Care Services includes any request that a Physician with knowledge of the Member's condition determines is a request involving urgent care.

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

Concurrent Review Request - A request for ongoing Inpatient or continued services while the Member is actively receiving care to determine continued Medical Necessity, appropriate level of care, and length of stay.

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

Timing of Initial Benefit Determinations

We will make our benefit decisions within the timeframes listed below. Please call Member Services at 1-833-230-2099 with any questions you may have.

Review Request Category	Timeframe for Making Decision
Concurrent Care Reviews	Within seventy-two (72) hours from the receipt of the request.
Urgent Care Reviews	Within the earlier of seventy-two (72) hours of receipt or two (2) business days.
Preservice Care Reviews	Within two (2) business days of our receipt of all necessary information to support your request.
Retrospective Care Reviews	Within thirty (30) calendar days of our receipt of your request.

Notification of Benefit Determinations

We will provide notification of our decision in accordance with state and federal regulations. Notification is given to the Covered Person by mail or another means of communication. Note: Prior to providing notification to you via electronic means, we must obtain advanced written consent from you or your Authorized Representative.

If we approve your request for Benefits or Health Care Services, we will provide you with notice of our

decision. However, even if we give Prior Authorization for Health Care Services, such Prior Authorization does not guarantee that the Plan will provide Benefits for such Health Care Services. 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 within ten (10) Business Days which will include your right to appeal.

SECTION 4 – IMPORTANT INFORMATION ON EMERGENCY, URGENT CARE, AND INPATIENT SERVICES

This section includes information on:

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

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

Emergency Medical Services

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

You do not have to obtain our authorization before you get Emergency Medical Services. If you have or think you have an Emergency Medical Condition, call 911 or go to the nearest Emergency Room or other appropriate setting. If you are not sure whether you need to go to the Emergency Room, call your PCP or our 24-Hour Nurse Advice Line. Your PCP or our 24-Hour Nurse Advice Line can talk to you about your medical problem and give you advice on what you should do.

Remember, if you need Emergency Medical Services:

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

If the Hospital admits you for Observation Stay or Inpatient level of care for after stabilization of your Emergency Medical Condition, Prior Authorization is not required. CareSource Members that receive Emergency Medical Services for an Emergency Medical Condition will only be financially responsible for in-network cost-sharing amounts as a result of the care.

Notice to Your PCP or CareSource Following Emergency Care

If you receive Emergency Medical Services at an Emergency Room (whether inside or outside the Service Area), and the Hospital admits you for Observation Stay but are not admitted to Inpatient, you or someone acting on your behalf must call your PCP and CareSource within forty-eight (48) hours of Observation Stay or as soon as reasonably possible. This will allow your PCP to provide or arrange for any follow-up care that you may need.

Emergency Medical Services Received from Non-Network Providers

If you received Emergency Medical Services and/or Emergency Ambulance Services from a Non-Network Provider, the services do not require Prior Authorization and will be considered Covered Services. Any applicable Copayment, Coinsurance, Annual Deductible, and/or Annual Out-of-Pocket Maximum requirements will be the same as if you obtained the Emergency Medical Services and/or Emergency Ambulance Services from a Network Provider. Non-Network Providers who render Emergency Medical Services to you should not send you a bill. If you receive a bill from a Non-Network Provider for the provision of Emergency Medical Services, please contact us immediately at the number on your ID Card, and we will help you with the bill.

Transfer

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

Coverage for Urgent Care Services Outside the Service Area

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

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

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

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

Inpatient Hospital Stay

Inpatient Hospital Services

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

Charges After Your Discharge from a Hospital

If you choose to stay as an Inpatient after a Physician has scheduled your discharge or determined that further Inpatient Services are no longer Medically Necessary, the Plan will not pay for any of the costs incurred after your scheduled discharge or after Inpatient Services are determined to be no longer Medically Necessary. CareSource will comply with statutory requirements outlined within the No Surprises Act regarding any Covered Services received by you from Non-Network Providers.

How Benefits are Paid

Benefits provided pursuant to this section are payable at the Network level and are limited to the Maximum Allowable Amount. Our coverage is subject to your Coinsurance, Copayment, or Deductible. You may be responsible for any amount in excess of the Maximum Allowable Amount if you do not follow the appropriate steps before seeing a Non-Network Provider.

SECTION 5 – YOUR COVERED SERVICES

This section includes information on:

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

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

All Covered Services are subject to the conditions, Exclusions, limitations, terms and provisions of this EOC, including any Riders/Enhancements or Amendments. Covered Services must be Medically Necessary and not Experimental, Investigational, or Unproven. The fact that a Provider may prescribe, order, recommend or approve Health Care Services does not make them Medically Necessary or Covered Services and does not guarantee payment. To receive maximum Benefits for Covered Services, you must follow the instructions outlined in this EOC, including receipt of care from a Network Provider, and obtaining any required Prior Authorization. Please refer to Section 3: *How the Plan Works, Prior Authorization.* Visit our website at CareSource.com/mp-NV-pa to review the Prior Authorization list or contact Member Services.

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

1. AMBULANCE SERVICES

Description

The Plan provides Benefits for Emergency Ambulance transport to the nearest Hospital Emergency Room or independent freestanding emergency department that can provide treatment.

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

- 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 Medical 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.

Excluded Services

The following Ambulance Services are not Covered Services or have limitations:

- When provided by ambulettes or similar vehicles, including taxi or other means of public transportation.
- Trips to a Physician's office, clinic, morgue or funeral home.

2. AUTISM SPECTRUM DISORDER SERVICES

Description

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

Benefit	Benefit Limit
Inpatient Services:	None
Diagnostic Evaluations[1]:	None
Screening, Testing, and Assessments[1]	None
Outpatient Services:	
Adaptive Behavior Treatment, including Applied Behavioral Analysis (ABA)	None
Behavioral / Mental Health Therapy Services:	
Crisis Intervention	None
Intensive Outpatient Program (IOP) Services	None
Partial Hospitalization Program (PHP) Services	None
Psychiatry	None
Psychotherapy	None
Occupational Therapy	None
Physical Therapy	None
Speech Therapy	None

[1]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 rendered in accordance with the statewide standard for measuring outcomes and assessing persons with autism spectrum disorders pursuant to NRS 427A.872.

Outpatient Services include:

- Adaptive Behavioral Treatment – includes Applied Behavioral Analysis, must be provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan pursuant to NRS 629.031.
- Behavioral / mental health therapy services – performed by an appropriate licensed or credentialed Behavioral Health Care Service Provider to provide consultation assessment, development and oversight of treatment plans.
- Habilitative occupational, physical, or speech therapy – performed by a licensed therapist.

Excluded Services

The following Autism Spectrum Disorder Services are not Covered Services or have limitations:

- Health Care Services for the primary diagnosis of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Health Care Services that are not backed by credible research demonstrating a measurable and beneficial health outcome and are considered as Experimental or Investigational or as Unproven Service.
- Health Care Services under this section when Covered Person does not have an Autism Spectrum Disorder diagnosis.
- 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.
- Health Care Services for the primary diagnosis of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilics.
- Health Care Services for the diagnosis or treatment of a Behavioral Health Disorder which are:
  - Inconsistent with generally accepted standards of medical practice for the treatment of such conditions.
  - 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, Investigational, or Unproven.
  - Not consistent with the current level of care guidelines or best practices as may be modified from time to time.
  - Not clinically appropriate for the patient's Behavioral Health Disorder or condition based on generally accepted standards of medical practice and benchmarks.

3. BEHAVIORAL HEALTH CARE AND SUBSTANCE USE DISORDER SERVICES

Description

The Plan provides Benefits for Behavioral Health Care Services (mental health and Substance Use Disorder) as described below. Coverage for the diagnosis and treatment of a Behavioral Health Disorder will not be subject to any limitations, including Annual Deductibles, Copayment, and Coinsurance provisions that are less favorable than the limitations that apply to a physical Sickness as covered under this EOC. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

Benefit	Benefit Limit
American Society of Addiction Medicine (ASAM) Intensive Outpatient Level of Care	Adolescents: 6 or More Hours Per Week Adults: 9 or More Hours Per Week
Inpatient Services	None
Intensive Outpatient Program (IOP) Services	3 Hours Per Day; 2-3 Days Per Week
Opioid Treatment Program (OTP)	None
Outpatient Services	None
Partial Hospitalization Program (PHP) Services	None
Residential Treatment Services	None

American Society of Addiction Medicine (ASAM) Intensive Outpatient Level of Care. The Plan provides Benefits for intensive Outpatient level of care services offered by practice groups or Facilities that provide Substance Use Disorder Treatment. ASAM intensive Outpatient level of care services are defined as those that provide six (6) hours or more of treatment per week for adolescents, or nine (9) hours or more of treatment per week for adults. ASAM intensive Outpatient level of care services treat multidimensional instability, particularly services meeting complex needs of members with addiction and co-occurring conditions.

Inpatient Stays. The Plan provides Benefits for Behavioral Health Care Services you receive during an Inpatient admission or confinement for acute Inpatient Services for mental health and Substance Use Disorder services provided in a Hospital or other health care treatment Facilities providing acute Inpatient Services. These services include Inpatient electroconvulsive therapy (ECT), psychiatric hospitalization, Inpatient detoxification treatment, and Emergency evaluation and stabilization.

Intensive Outpatient Program (IOP) Services. The Plan provides Benefits for intensive Outpatient program services offered by practice groups or Facilities that provide mental health services. Intensive Outpatient program services 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 program services may offer group, dialectical behavior therapy, individual, and family therapy. These programs are usually used as a step down from acute Inpatient care, residential care, or a partial hospitalization program. They may also be viewed as a step up from regular Outpatient Services.

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

Outpatient Services. The Plan provides Benefits for office-based Behavioral Health Care Services. These include assessments, screenings and testing, counseling, crisis services, diagnostic evaluation, medication management, psychiatry, psychological testing, and psychotherapy (family, group, and individual).

Partial Hospitalization Program (PHP). The Plan provides Benefits for Behavioral Health Care Services you receive at an outpatient Partial Hospitalization Program. PHP is a treatment service for Behavioral Health Disorders with a treatment period of three (3) or more hours per day up to five (5) days per week in which the Covered Person is assisted with issues related to the individual's reintegration into society. Partial hospitalization items and services that can be included as part of the structured, multimodal active treatment program include:

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

Residential Treatment Services. The Plan provides Benefits for Behavioral Health Care Services in a Residential Treatment Program. These Health Care Services can include individual and group psychotherapy, family counseling, nursing services, Medication Assisted Treatment, ambulatory or subacute detoxification, and pharmacological therapy in a congregate living community with 24-hour support.

Excluded Services

The following Behavioral Health Care and Substance Use Disorder Services are not Covered Services or have limitations:

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

4. CHIROPRACTIC CARE SERVICES

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

5. CLINICAL TRIALS

Description

The Plan provides Benefits for routine patient Health Care Services you receive as part of an approved Clinical Trial provided that such Health Care Services are otherwise Covered Services under the Plan. Please see Section 2: *Definitions*, for what constitutes an approved Clinical Trial.

Excluded Services

The following Clinical Trial services are not Covered Services or have limitations:

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

6. DENTAL SERVICES

Accidental Dental Services

The Plan provides Benefits for Outpatient Services, Physician Services – Office Visits, Emergency Health Care Services and Urgent Care Services for dental work and oral surgery if they are for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are

not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting your condition. "Initial" dental work to repair injuries due to an accident means performed within twelve (12) months from the Injury, or as clinically appropriate and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to a dental related Injury, the Plan may provide Benefits, at its discretion, even if there may be several years between the accidental Injury and the final repair. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

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

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

The services above are covered without the applicable accident related limitations, as medical dental services, when received for the following Medically Necessary reasons:

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

Dental Anesthesia Services

The Plan also covers safety-based Dental Health Care Services 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:

- with serious mental or physical conditions, or
- with significant behavioral problems.

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.

Excluded Services

The following Dental Services are not Covered Services or have limitations:

- The provisions of this section may not be construed to require coverage for the dental care for which the safety-based anesthesia is provided.
- Injury as a result of chewing or biting is not considered an accidental Injury, and Health Care Services related to such injuries are not Covered Services.

7. DIABETES EDUCATION, EQUIPMENT AND SUPPLIES

Description

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

- Medically Necessary;

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

Covered Services also include all Physician or Podiatrist prescribed Medically Necessary services, equipment and supplies used for the management and treatment of diabetes. Please see Section 5: *Your Covered Services*, *Durable Medical Equipment, Medical and Surgical Supplies, Orthotics and Prosthetics,* Section 5: *Your Covered Services, Physician Services – Office Visits*, and Section 5: *Your Covered Services, Preventive Health Care Services* Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

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

8. DIAGNOSTIC SERVICES

Description

The Plan provides Benefits for non-invasive Diagnostic Services, including the below. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

- Advanced Imaging such as: MRI, MRA, PET, SPECT and CT imaging procedures, including cardiographic, and radioisotope tests
- Biomarker testing as determined Medically Necessary
- Bone density testing
- Coverage for breast cancer imaging, including mammograms, breast ultrasound, and breast MRI
- Laboratory and pathology services, including allergy testing and encephalographic tests
- X-ray/radiology services.

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

9. DURABLE MEDICAL EQUIPMENT, MEDICAL AND SURGICAL SUPPLIES, ORTHOTICS AND PROSTHETICS

Benefits are available for Durable Medical Equipment, Medical and Surgical Supplies, Orthotics and Prosthetics described below. The Durable Medical Equipment, medical and surgical supplies, orthotics and prosthetics will only be Covered Services if they are Medically Necessary.

A. Adjustment, Repair, and Replacement

The Plan may cover the adjustment, repair, and replacement of purchased Durable Medical Equipment, medical and surgical supplies, orthotics, and prosthetics when approved by us. The adjustment, repair, or replacement of the purchased Durable Medical Equipment, medical and surgical supplies, orthotics, and prosthetics is covered if:

- The Durable Medical Equipment, medical and surgical supplies, orthotics, and prosthetics is a Covered Service;
- The continued use of the item is Medically Necessary; and
- There is reasonable justification for the adjustment, repair, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased Durable Medical Equipment, medical and surgical supplies, orthotics,

and prosthetics may be covered if:

- The Durable Medical Equipment, medical and surgical supplies, orthotics, and prosthetics 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 Durable Medical Equipment, medical and surgical supplies, orthotics, and prosthetics is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

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

B. Durable Medical Equipment

The Plan provides Benefits for certain Durable Medical Equipment, as described in this section. A single purchase of each type of Durable Medical Equipment including repair/adjustment and/or replacement, every three (3) years is covered. 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:

- Augmentative communication devices are covered when we approve based on your condition
- Blood pressure cuff
- Cardiac, neonatal and sleep apnea monitors
- Continuous Positive Airway Pressure (CPAP) machines when indicated for sleep apnea and Noninvasive Positive Pressure Ventilation (NPPV)
- Crutches and replacement of pads and tips
- Glucometer (select Brands are covered under the Prescription Drug Formulary)
- Hemodialysis equipment
- Hospital beds
- Infusion pump for IV fluids and medicine
- Insulin infusion pump
- Motorized wheelchair
- Oxygen equipment
- Pressure machines
- Tracheotomy tube
- Wearable cardioverter defibrillators and necessary accessories
- Wheelchairs
- Wound vacuums
- Other Durable Medical Equipment as approved by us, except those that are excluded

Limitations

A single purchase of each type of Durable Medical Equipment including repair/adjustment and/or replacement, every three (3) years.

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

Excluded Services

The following Durable Medical Equipment items are not Covered Services or may have limitations:

- 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.

C. Medical and Surgical Supplies

Covered Services for Medical and Surgical Supplies include but are not limited to:

- 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.
- Allergy serum extracts.
- Catheters.
- Clinitest.
- Colostomy and ostomy bags and supplies provided; however, the Plan does not provide Benefits for Health Care Services related to the fitting of such bags and supplies.
- Compression/gradient compression stockings.
- Diabetic testing supplies - a limited list of diabetic testing supplies is covered on the Prescription Drug Formulary.
- Needles, oxygen, splints, surgical dressings, and other similar items which serve only a medical purpose.
- Surgical bras – limited to four (4) per year as required by the Women's Health and Cancer Rights Act.
- Therapeutic food, formulas, supplements, low-protein modified food products and amino acid-based formula 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. This Benefit does not apply to those Covered Persons with an intolerance for lactose or soy. Benefits available for their use are limited to conditions required by law.
- Other medical and surgical supplies as approved by us, except those that are excluded.

We may establish reasonable quantity limits for certain Durable Medical Equipment, medical and surgical supplies, orthotics, and prosthetics as described below.

Excluded Services

The following Medical and Surgical Supplies items are not Covered Services or have limitations:

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

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

D. Orthotics

The Plan provides Benefits for certain orthotic devices. Covered Services include one (1) initial purchase per affected limb and replacement every three years 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. 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. Orthotic devices include Medically Necessary custom fabricated braces or supports that are designed as a component of a prosthetic device. The cost of casting, molding, fittings, and adjustments are covered. Orthotic devices should be purchased not rented and must be Medically Necessary. 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:

- Ankle foot orthosis.
- Back and special surgical corsets.
- Build-up shoe.
- Cervical collars.
- Cranial remodeling helmets (limit of one (1) per lifetime).
- Custom made shoe inserts.
- Foot support devices, including arch supports and corrective shoes, when part of an integral leg brace.
- Knee orthosis.
- Slings.
- Splints (extremity).
- Therapeutic shoes.
- Trusses and supports.
- Wristlets.
- Other orthotics as approved by us except those that are excluded.

Limitations

A single purchase of each type of orthotic including repair/adjustment and/or replacement, every three (3) years. 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 replacement is due to your rapid growth.

Excluded Services

The following Orthotics are not Covered Services:

- Orthopedic shoes.
- Non rigid orthotics, such as standard elastic stockings, garter belts, corsets and other supplies not specifically made and fitted (except as specified under Medical and Surgical Supplies).

If you have any questions about whether a specific orthotic is covered, please call the Member Services number on the back of your ID Card, we would be happy to assist.

E. Prosthetics

The Plan provides Benefits for certain prosthetics. The Plan covers artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include one (1) initial purchase per affected limb and replacement every three (3) years that:

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

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

Covered Services for prosthetics include, but may not be limited to:

- 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.
- Artificial eyes and limbs.
- Breast prosthesis whether internal or external, following a mastectomy as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
- Cochlear implant.
- 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.
- Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
- Osseointegrated auditory devices (bone anchored hearing aids). Limited to one (1) initial purchase per lifetime and one (1) replacement per year.
- Restoration prosthesis (composite facial prosthesis).
- Other prosthetics as approved by us, except those that are excluded.

Limitations

A single purchase of each type of prosthetic including repair/adjustment and/or replacement, every three (3) years.

Excluded Services

The following Prosthetics are not Covered Services:

- Artificial heart implants.
- Dental appliances when the primary diagnosis is dental in origin. This exclusion does not apply to dental appliances for which Benefits are provided as described under Section 5.
- Denture, replacing teeth or structures directly supporting teeth.
- Occlusal adjustments.
- Penile prosthesis when the primary diagnosis is suffering from impotency resulting from disease or Injury.
- Wigs

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

10. EMERGENCY HEALTH CARE SERVICES

Description

The Plan provides Benefits for Emergency Health Care Services to evaluate, Stabilize, or treat an Emergency Medical Condition in a Hospital Emergency Room or an independent freestanding emergency department. Health Care Services which we determine to meet the definition of Emergency Medical Services will be Covered Services, whether the care is rendered by a Network Provider or a Non-Network Provider. Please refer to the *Services Provided by Non-Network Providers* within Section 3: *How the Plan Works* and Section 4: *Important Information on Emergency, Urgent Care, and Inpatient Services* for further details.

Whenever you are admitted as an Inpatient directly from a Hospital Emergency Room, the entire visit, including Emergency Medical Services received in the Emergency Room, will be treated as an Inpatient Stay, and the applicable Copayment and Coinsurance will apply. See the Schedule of Benefits for applicable Copayment and Coinsurance amounts.

Excluded Services

Health Care Services in an Emergency Facility which we determine to not meet the definition of Emergency Medical Services will not be covered.

11. ENDOMETRIOSIS AND ENDOMETRITIS

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

12. GENDER DYSPHORIA AND GENDER INCONGRUENCE

Healthcare services cover psychosocial, surgical interventions and other services for gender dysphoria and gender incongruence based on Medical Necessity.

13. HABILITATIVE SERVICES – OUTPATIENT THERAPY

Description

Habilitative Services are Health Care Services provided on an Outpatient basis that help you keep, learn, or improve skills and functioning for daily living. An example is therapy for a child who is not walking or

talking at the expected age. These services may include physical and occupational therapy, speech therapy or speech pathology services, and other services for people with disabilities.

Benefit	Benefit Limit
Manipulation Therapy (MT)	20 Visits Per Year
Occupational Therapy (OT) Physical Therapy (PT) Speech Therapy (ST)[1]	Combined 120 Visits Per Year for Habilitative OT, PT, and ST Inpatient Days and Outpatient Visits

[1] Speech therapy for the treatment of stuttering will not be subject to any quantity limits.

Benefits are provided for Habilitative Services for Covered Persons with a congenital, genetic, or early acquired disorder when 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.

For purposes of this Benefit, a “congenital or genetic disorder" includes, but is not limited to, hereditary disorders. "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.

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.

Excluded Services

The following Habilitative Services are not Covered Services or have limitations:

- Health Care Services previously considered Habilitative Services when the Covered Person has reached their maximum level of improvement or does not demonstrate continued progress under a treatment plan
- Health Care Services that are solely educational in nature or otherwise paid under state or federal law for purely educational services
- Health Care Services that do not help the Covered Person meet functional goals in a treatment plan within a prescribed timeframe
- Custodial Care
- Day Care
- Residential Treatment
- Respite care
- Therapeutic recreation
- Vocational training

14. 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:

- Diagnostic Services.
- Durable Medical Equipment, Medical and Surgical Supplies, Orthotics and Prosthetics.
- 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.
- Home Infusion Therapy services, which 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.
- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- One (1) medical social service visit per course of treatment.
- One (1) nutritional guidance visit by a certified registered dietician per course of treatment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).
- Private duty nursing.
- Therapy Services (except those listed as excluded). Home Care Visit limits specified in the Schedule of Benefits for Home Health Care Services apply when Therapy Services are rendered in the home.

Excluded Services

The following Home Health Care Services are not Covered Services or have limitations:

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

15. HOSPICE SERVICES

Description

The Plan provides Benefits for Hospice services if you have a Terminal Illness. Hospice care is a

coordinated plan of home, Inpatient, and Outpatient care that provides palliative and supportive medical, social, and psychological services to terminally ill patients. Hospice services include routine home care and continuous home care.

To be eligible for Hospice Benefits, you must have a Terminal Illness and a life expectancy of six (6) months or less, as confirmed by your attending Physician. Hospice Benefits will continue if you live longer than six (6) months.

Hospice services that qualify as Covered Services include, but are not limited to:

- Diagnostic Services
- Durable Medical Equipment, medical and surgical supplies, orthotics and prosthetics for palliative care
- Home health aide services
- Inpatient respite services
- Inpatient Stay at a Hospice Facility
- Medical social services and counseling services provided by a social worker
- Prescription Drugs given by the Hospice, including chemotherapy or radiation for palliative care
- Physical, speech and inhalation therapies, if part of a treatment plan
- Skilled Nursing Services (by an R.N. or L.P.N.)

Additional services through the Hospice coordinated care plan may be available as determined by us.

Excluded Services

Respite services are limited to a combined maximum benefit of five (5) Inpatient days or five (5) Outpatient visits per Member per ninety (90) days of home hospice care.

The following Hospice Services are not Covered Services:

- Housekeeping services
- Durable Medical Equipment, medical and surgical supplies, orthotics and prosthetics used to treat you when the Facility you are in should provide such equipment
- Services provided by volunteers
- Services provided that are not a part of the coordinated plan of care described above

For additional exclusions, see Section 7: *What Is Not Covered*.

16. INFERTILITY SERVICES

Description

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

Artificial insemination services. Oocyte and sperm preservation services including evaluation expenses, laboratory assessments, medications, and treatments associated with oocyte and sperm cryopreservation procedures, including obtaining, freezing, and storing gametes.

Limitations

- Lifetime limit of six (6) cycles of artificial insemination per Member.
- Oocyte and sperm preservation services when a diagnosis or Medically Necessary treatment for breast

or ovarian cancer may directly or indirectly cause impairment of fertility (iatrogenic infertility).
- Lifetime limit of one (1) oocyte or cryopreservation procedure per Member.
- Benefits are not available for long term storage costs (greater than one year).

Not all services connected with the treatment of infertility are Covered Services. Refer to Section 7:*What Is Not Covered*.

17. INPATIENT SERVICES

Description

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

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

For Benefits related to surgery and anesthesia services, please see Section 5: *Your Covered Services*, *Surgical Services* and for Benefits related to post-delivery newborn services while Inpatient, see Section 5: *Your Covered Services, Maternity Services*.

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

Whenever you are admitted as an Inpatient directly from a Hospital Emergency Room, the entire visit, including Emergency Health Care Services received in the Emergency Room, will be treated as an Inpatient Stay, and the applicable Copayment and Coinsurance in the Schedule of Benefits will apply.

For Inpatient Services as part of Emergency Medical Services for an Emergency Medical Condition, please refer to Section 3: *How the Plan Works, Services Provided by Non-Network Providers* and Section 4: *Important Information on Emergency, Urgent Care, and Inpatient Services* for further details.

The Plan provides Benefits for a maximum of one hundred (100) days per year for Skilled Nursing Facility stays.

The Plan provides Benefits for a combined one hundred twenty (120) visits per year for rehabilitative occupational, physical and speech therapy Inpatient days and Outpatient visits. Speech therapy for the treatment of stuttering will not be subject to any quantity limits.

The Plan provides Benefits for a combined one hundred twenty (120) visits per year for habilitative occupational, physical and speech therapy Inpatient days and Outpatient visits. Speech therapy for the treatment of stuttering will not be subject to any quantity limits.

Excluded Services

The following Inpatient Services are not Covered Services or have limitations:

- Private duty nursing
- The following consultations:
  - Staff consultations required by Hospital rules;
  - Consultations requested by you;
  - Routine radiological or cardiographic consultations;
  - Telephone consultations; and
  - EKG transmittal by phone.

18. MATERNITY SERVICES

Description

The Plan provides Benefits for Maternity Services. Maternity Services include Inpatient Services, Outpatient Services and Physician Services – Office Visits. These services are used for normal or complicated Pregnancy, miscarriage, Therapeutic Abortion, ordinary routine nursery care for a healthy newborn, and a newborn exam. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

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

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

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

For a newborn, Covered Services while in the Network Hospital during the first 48 hours or 96 hours following birth, as applicable and listed above, will include Hospital charges for routine nursery care, circumcision of newborn child, and routine examination of newborn for release from the Hospital. For the newborn exam, a Physician other than the Physician who performed the obstetrical delivery must do the examination.

The Plan covers insertion or injection of long-acting reversible contraception at the request of Members who are receiving Inpatient Hospital care for childbirth.

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

- Health Care Services needed to treat Injury or Sickness;
- Care or treatment of premature birth; and
- Medically diagnosed congenital defects and birth abnormalities.

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

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

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

At your discretion, these visits may occur at the Physician's office.

Excluded Services

The following Maternity Services are not Covered Services or have limitations:

- For an abortion, except a Therapeutic Abortion as defined in Section 2: *Definitions*.
- If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

19. 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, other therapy services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation), or other Provider Facility as determined by us. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.

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

For Observation Stays or Outpatient Services as part of Emergency Medical Services for an Emergency Medical Condition, please refer to Section 3: *How the Plan Works, Services Provided by Non-Network Providers* and Section 4: *Important Information on Emergency, Urgent Care, and Inpatient Services* for further details.

20. PHYSICIAN SERVICES - OFFICE VISITS

Description

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

- **Office Visits** for medical care and consultations to examine, diagnose, and treat a Sickness or Injury performed in the Provider's office. Office visits also include allergy testing, injections and serum. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits.
- **Home Visits** for medical care and consultations to examine, diagnose, and treat a Sickness or Injury performed in your home.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and surgical services** (including anesthesia and supplies) including normal post-operative care.
- **Telehealth Services** see Section 5: *Your Covered Services, Telehealth Services* for more information.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider. See Section 5: *Your Covered Services, Habilitative Services – Outpatient Therapy* and *Rehabilitative Services – Outpatient Therapy* for more information.

21. PRESCRIPTION DRUGS

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

22. PREVENTIVE HEALTH CARE SERVICES

The Plan provides Benefits for Preventive Health Care Services, including family planning services, as part of your Essential Health Benefits, as determined by federal and state law. Coverage provided is equal to or greater than federal and state law. Preventive Health Care Services can fall into two categories: (1) federally mandated Preventive Health Care Services (required to be paid with no member cost share) and (2) state mandated Preventive Health Care Services. Where both federal and state mandated guidelines speak to the same preventive service, you will have access to the broadest benefit between the two. You may call Member Services for additional information about these services.

Preventive Health Care Services in this section must meet requirements as determined by federal and state law. The Plan will cover these Preventive Health Care Services at no cost to you if provided by a Network Provider. Preventive Health Care Services fall under four broad categories. The categories are:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF). For a complete list of recommended services, please visit: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. Examples of these services are screenings for:
  - Breast cancer (mammogram)
  - Cervical cancer
  - Child and adult obesity
  - Cholesterol
  - Colorectal cancer (colonoscopy)
  - High blood pressure
  - Type 2 diabetes mellitus
- 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 (HRSA), including:
  - Food and Drug Administration (FDA) approved women's contraceptives including self-administered hormonal contraceptives dispensed without a prescription, sterilization procedures, and counseling.
  - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one breast pump per pregnancy.
  - Screening for diabetes in pregnancy.

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

- Prostate cancer screening. One prostate specific antigen test is covered annually for a Covered Person who either is at least fifty (50) years of age or who is less than fifty (50) years of age and at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.
- Child health supervision services from the moment of birth until age 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 state 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. See Section 5: *Your Covered Services, Routine Hearing Services, Hearing Aids, and Related Services*, for more information. For newborn hearing screening, see Section 5: *Your Covered Services*, *Maternity Services*.
- Sports physicals for children who are in elementary school through high school.
- Breast Cancer Genetic Test Counseling (BRCA1 and BRCA2) which includes mutation testing for individuals who have family members with breast, ovarian, fallopian tube, or peritoneal cancer.
- Preventive Benefits for screening mammograms provided under CareSource's general coverage is equal to or greater than the following:
  - An annual mammogram for Members 40 years of age or older.
  - Imaging tests to screen for breast cancer on an interval and at the age deemed most appropriate,

when Medically Necessary, as recommended by the Member's PCP based on personal or family medical history or additional factors that may increase the risk of breast cancer.

- Tobacco cessation services: one (1) screening for tobacco use; and two (2) cessation attempts per Benefit Year, consisting of four (4) sessions of telephone, individual and group cessation counseling lasting at least ten (10) minutes each per quit attempt and all medications approved by the United States Food and Drug Administration as safe and effective for smoking cessation, for ninety (90) days per quit attempt, when prescribed by your Provider.
- Lung cancer screening. The American Cancer Society recommends yearly screening for lung cancer with a low-dose CT (LDCT) scan for people aged 50 to 80 years who smoke or used to smoke and have at least a 20 pack-year history of smoking.
- Human Immunodeficiency Virus (HIV) screening and counseling.
- Rapid point-of-care test for syphilis.
- Unrestricted coverage of condoms for Members aged thirteen (13) years old or older. Refer to your Prescription Drug Formulary.

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

23. 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 but are not limited to the following:

- Breast and chest wall reconstruction with aesthetic flat closure resulting from a mastectomy as required by the Women's Health and Cancer Rights Act. This includes reconstructive surgery of the breast on which the mastectomy has been performed and surgery and reconstruction on the non-diseased breast to achieve symmetrical experience. See Section 12: *Other Important Information*, *Women's Health and Cancer Rights Act Notice*.
- Care and treatment necessary for medically diagnosed congenital defects and birth anomalies:
  - Cleft lip and cleft palate.
  - Congenital disorders that cause skull deformity such as Crouzon's disease.
  - Hemangiomas, and port wine stains of the head and neck areas for children 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.
- Other reconstructive services as approved by us, except those that are excluded.

24. REHABILITATIVE SERVICES – OUTPATIENT THERAPY

Description

The Plan provides Benefits for certain rehabilitation services if given as part of Physician Services – Office Visits, or on an outpatient basis at a Hospital or Alternate Facility when a Network Provider expects that the therapy services will result in a practical improvement in the level of your functioning within a reasonable

period of time.

Benefit	Benefit Limit
Physical Therapy Speech Therapy[1] Occupational Therapy	A combined maximum of 120 days/visits per year for Inpatient and Outpatient Rehabilitation services
Manipulation Therapy	20 Visits

[1] Speech therapy for the treatment of stuttering will not be subject to any day/visit limits.

Physical Therapy Services

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

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

Occupational Therapy Services

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

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

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

Speech Therapy

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

Manipulation Therapy

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

services provided in the home as part of Home Health Care Services.

Other Rehabilitation Therapy Services

Benefit	Benefit Limit
Cardiac Rehabilitation	None
Pulmonary Rehabilitation	None
Post-Cochlear Implant Aural Therapy	See Speech Therapy Limit
Chemotherapy	None
Dialysis	None
Radiation Therapy	None
Inhalation Therapy	None

The Plan will provide Benefits for therapy services for:

- **Cardiac Rehabilitation** –to restore your functional status after a cardiac event. Cardiac rehabilitation services include a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Pulmonary Rehabilitation** –to restore an individual's functional status after a Sickness or Injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short- term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling.
- **Post-Cochlear Implant Aural Therapy.**
- **Chemotherapy -** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis -** for the treatment 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); material and supplies used in therapy, treatment and planning.
- **Inhalation Therapy -** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics of inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

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

Description

The Benefits available to you under this section are administered by TruHearing®. The management and other services that TruHearing provides include, among others, maintaining and managing the Network Providers who will provide Covered Services to you under this section. You must use a TruHearing Network

Provider in order to receive Benefits under this section. If you do not use a TruHearing Network Provider to receive Health Care Services under this section, you will be responsible for all costs and such Health Care Services will be considered Non-Covered Services. Please call 1-866-202-2561 for help locating a TruHearing Network Provider and for additional information and details.

The Plan provides Benefits for the following routine hearing services:

- Routine Hearing Screening: One (1) screening per Benefit Year which includes a simple pass or fail test to determine if you have normal hearing or not. Usually consists of a series of beeps or tones at the limit of normal range. For newborn hearing screening, see Section 5: *Your Covered Services*, *Maternity Services*.
- Routine Hearing Exam: One (1) exam per Benefit Year including a comprehensive examination performed by a licensed audiologist or hearing instrument specialist that generally includes a review of your full case history, several types of hearing tests, counseling to understand results, and recommendations on appropriate treatment.
- Hearing aid and related services are limited to one (1) hearing aid per hearing impaired ear every thirty-six (36) months.
  - For coverage of bone anchored hearing aids and cochlear implants, see Section 5: *Durable Medical Equipment, Medical and Surgical Supplies, Orthotics and Prosthetics*.
  - To be Covered Services, hearing aids must be listed on the approved Hearing Aid List. The approved Hearing Aid List is subject to periodic review and amendment. Hearing aids must be Medically Necessary in order to be Covered Services. Hearing aids on our approved Hearing Aid List are subject to the applicable Copayment, Coinsurance, and Deductible requirements of the Plan. The approved Hearing Aid List is available by calling 1-866-202-2561.
  - Hearing aid purchased includes:
    - first year of follow up provider visits
    - 60-day trial period
    - 3-year extended warranty
    - 80 batteries per aid for non-rechargeable models

Excluded Services

Non-routine and medical based hearing exams are not covered within this category of this Evidence of Coverage.

26. STERILIZATION

Description

The Plan provides Benefits for 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.

Reversals of sterilization are not Covered Services.

27. SURGICAL SERVICES

Description

The Plan provides Benefits for surgical services when provided as part of Inpatient Stays, Outpatient Services, or Physician Services – Office Visits. 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:

- Anesthesia and surgical assistance when Medically Necessary (including when provided by a registered nurse first assistant, certified surgical assistant, or physician assistant)
- Bariatric surgery – limited to one (1) procedure per lifetime
- Breast reduction surgery – Covered Services include prior authorized as Medically Necessary for treatment of macromastia and gynecomastia. For reconstructive breast surgery following mastectomy, see Section 5: *Your Covered Services*, *Reconstructive Services*.
- Correction of fractures and dislocations
- Mastectomy
- Performance of accepted operative and other invasive procedures, including but not limited to:
  - Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
  - Operative and cutting procedures; and
  - Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.
- Usual and related pre-operative and post-operative care
- Other surgical services as approved by us, except those that are excluded

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

Excluded Services

The following Surgical Services are not Covered Services or have limitations:

- For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia, metatarsalgia; and hyperkeratoses.
- Weight reduction procedures other than bariatric surgery.

28. TELEHEALTH SERVICES

Description

Covered Services include a medical or health consultation for purposes of diagnosis and/or treatment using your Smartphone, tablet, computer or other computing device. Telehealth Services may be received from your PCP, other Network Provider, or through Teladoc Health®. See your member handbook or call Member Services for further details on how to schedule telehealth visits.

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

You should consider Teladoc Health Telehealth Services if:

- You are considering visiting an emergency or urgent care Provider for non-emergency health care; or
- You or your Dependent(s) need care immediately and your Physician or behavioral health Provider is not available.

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

Excluded Services

The following Telehealth Services are not Covered Services or have limitations:

- Normal communication with your PCP or other Network Provider, including but not limited to the following:
  - Benefit precertification
  - Billing, insurance coverage or payment questions
  - Office appointment requests or reminders (including voicemails)
  - Physician to Physician consultation
  - Reporting normal lab or other test results
  - Requests for referrals to doctors outside the online care panel
- Delivery of Health Care Services through the following means of communication:
  - Electronic mail
  - Fax transmission unless a state agency authorized or required
  - Instant messaging, including text messaging

29. TEMPOROMANDIBULAR, CRANIOMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR JAW DISORDER

Description

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

- Diagnostic procedures include an examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation as necessary, and x-rays.
- Non-surgical treatment includes appliance therapy utilizing an appliance which does not permanently alter tooth position, jaw position, or bite, physical therapy, and therapeutic injections.
  - Benefits for reversible appliance therapy will be based on the maximum allowable fee for use of a single appliance (may be limited to one (1) every three (3) years), regardless of the number of appliances used in treatment.
  - The Benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance.
  - Benefits for physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service.
  - Benefits for therapeutic injections include masticatory muscle, temporomandibular joint, and trigger point injections.
- Surgical treatment.

Excluded Services

The following Temporomandibular, Craniomandibular Joint Disorder, and Craniomandibular Jaw Disorder services are not Covered Services or have limitations:

- Any irreversible procedure, including but not limited to orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures or full dentures.
- Occlusal analysis.

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

Description

Covered Transfusion Services

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

Covered Transplant Procedure

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

Covered Services for human organ and stem cell/bone marrow transplants and transfusions are covered as Section 5: *Your Covered Services*, *Inpatient Services*, Section 5: *Your Covered Services*, *Outpatient Services* or Section 5: *Your Covered Services*, *Physician Services – Office Visits* depending on where the Health Care Service is performed.

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

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

Transplant Benefit Year

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

Transportation and Lodging

The Plan will provide reimbursement up to a maximum of ten thousand dollars ($10,000) per transplant for certain Benefits associated with your reasonable and necessary travel expenses as determined by us if you are required to travel more than seventy-five (75) miles from your residence to reach the Facility where your transplant procedure will be performed. Your Benefit includes assistance with your travel expenses, including transportation to and from the Facility and lodging for you, as the patient, and one (1) companion. If you are receiving treatment as a minor, reasonable and necessary expenses for transportation and lodging may be allowed for two (2) companions, 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. You must submit itemized receipts for transportation and lodging expenses in a form satisfactory to us when Claims are filed.

These Benefits are applicable to a Member that is either the transplant recipient or the donor. Forms that include detailed instructions for receiving your reimbursement can be found at CareSource.com.

Bone Marrow / Stem Cell Donor Search Fee

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 bone marrow/stem cell covered transplant procedure.

Authorization Requirements

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

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

Excluded Services

The following Transplant services are not Covered Services or have limitations:

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

31. 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 Services – Office Visits* earlier in this section.

Benefits are also available for Urgent Care Services received at a Non-Network Urgent Care Center in limited circumstances. Please refer to Section 3: *How the Plan Works, Services Provided by Non-Network Providers* for further detail.

32. VISION SERVICES

Description

The Plan provides vision Benefits for Members without eye disease or diagnosis beyond refraction to detect vision impairment.

Important Information

The Benefits available under this section are administered by EyeMed® for pediatric Members to the end of the month in which the child turns nineteen (19) years of age. The management and other services that EyeMed provides include, among others, maintaining and managing the Network Providers who will provide Covered Services to you under this section. You must use an EyeMed Network Provider in order to receive Benefits under this section. If you do not use an EyeMed Network Provider to receive Health Care Services under this section, you will be responsible for all costs, and such Health Care Services will be considered Non-Covered Services. Please call 1-833-337-3129 for help locating an EyeMed Network Provider and for additional information and details. Note: Adult routine vision services are available with plans that include our Adult Vision & Fitness Rider/Enhancement.

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

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

Covered Services

The Plan provides Benefits for the following pediatric vision services:

- **Examination Options:** Various types of examinations are available.
  - **Comprehensive Eye Exam with Dilation as Necessary:** Covered in Full, limited to one (1) per year. Includes dilation, if Medically Necessary.
  - **Standard Contact Lens Fit and Follow-Up**: Cost share applies, limited to one (1) per year if contacts are provided as Covered Services.
  - **Premium Contact Lens Fit and Follow-Up**: You are responsible for the cost of the exam less 10% discount. Limited to one (1) per year if contacts are provided as Covered Services.
- **Eyewear: You may choose prescription glasses or contacts.**
  - **Frame and Frame Fitting:** Covered in Full including provider designated frames. Limited to

one (1) per year.

- **Lenses:** Limited to one (1) pair of lenses per year. The Plan also provides Benefits for one (1) replacement pair of glasses per year if it is Medically Necessary, and subject to limitations and exclusions outlined in this EOC.
  - Lens Options:
    - Standard plastic or glass - $0 Copay
    - Single vision, conventional bifocal, conventional trifocal, lenticular: $0 Copay
    - Progressive Lens
      - Standard - $0 Copay
      - Premium tier 1 - $20 Copay
      - Premium tier 2 - $30 Copay
      - Premium tier 3 - $45 Copay
      - Premium tier 4 - $0 Copay, 80% of charge less $120 allowance
    - UV treatment - $0 Copay
    - Tint (gradient, fashion or solid) - $0 Copay
    - Glass-grey #3 prescription sunglass lenses – $0 Copay
    - Standard plastic scratch coating - $0 Copay
    - Standard polycarbonate – $0 Copay
    - Oversized - $0 Copay
    - Photochromatic / transitions plastic - $0 Copay
    - Anti-reflective coating
      - Standard - $45 Copay
      - Premium tier 1 - $57 Copay
      - Premium tier 2 - $68 Copay
      - Premium tier 3 – 80% of Charge
    - Blended segment lenses - $0 Copay
    - Intermediate vision lenses - $0 Copay
    - Polarized – 20% off retail price
    - Hi-Index lenses – 20% off retail price
- **Contact Lenses:** Covered in Full, one (1) choice of supply per year - in lieu of eyeglasses. Includes the following options:
  - Conventional contact lenses: one (1) pair per year
  - Daily wear / disposable: up to three (3) months' supply per year of daily disposable, single vision spherical
  - Extended wear disposables: up to six (6) months' supply per year of monthly or two (2) week disposable, single vision spherical or toric contact lenses.

- **Low Vision:** Low vision is a significant loss of vision but not total blindness.
  - **Supplemental Testing:** Diagnostic evaluation beyond a comprehensive eye examination including, but not limited to, an ocular function assessment, measurements, visual field evaluations. Limited to one (1) per year.
  - **Low Vision Aids:** Includes, but is not limited to spectacle-mounted magnifiers, hand-held or spectacle-mounted telescopes, hand-held and stand magnifiers, and video magnification. Limited to one (1) per year.
- **Retinal Imaging Benefit:** Covered in Full. Limited to one (1) per year.
- **Medically Necessary Contact Lenses:** In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions:

keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.
  - In the event that contact lenses are determined to be Medically Necessary, the contact lenses and associated services, including fit and follow-ups, will be Covered in Full with no limitation on the number of follow-ups required.
  - Medically Necessary contact lenses are dispensed in lieu of other eyewear.

Additional services

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

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

Administered Through CareSource

The following Vision Services that are Covered Services which are administered through CareSource's Network of Providers:

- Non-routine eye exams for pediatric and adult Covered Persons with an eye disease or diagnosis beyond refraction to detect vision impairment.

Exclusions

The following Vision Services are not Covered Services or have limitations:

- Any charges for failure to keep a scheduled appointment;
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Any vision service, treatment or materials not specifically listed as a Covered Service;
- Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
- Eye surgery to correct errors of refraction, such as near-sightedness, including without limitations LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy;
- Health Care Services and materials not meeting accepted standards of optometric practice;
- Insurance of contact lenses, except as explained herein;
- Non-prescription (Plano) lenses;
- Office infection control charges;
- Prosthetic devices and services;
- Purchase cost and fitting charge for eyeglasses and contact lenses for adults age nineteen (19) years (starting the month after turning age nineteen (19)) and older without the Adult Vision and Fitness Rider/Enhancement;
- Replacement of lost/stolen eyewear;
- Routine eye exams for adults age nineteen (19) years (starting the month after turning age nineteen

(19) and older without the Adult Vision and Fitness Rider/Enhancement;

- Routine services provided by providers not within the EyeMed Network of Providers;
- Services and materials incurred after the termination date of your coverage unless otherwise indicated;
- Services and materials resulting from your failure to comply with professionally prescribed treatment;
- Services and materials that are Experimental, Investigational, or Unproven;
- Services not performed by licensed personnel;
- Services or materials which are rendered prior to your effective date;
- Special lens designs or coatings other than those described in this section;
- State or territorial taxes on vision services performed;
- Telephone consultations;
- Two (2) pairs of eyeglasses in lieu of bifocals; and
- Vision therapy.

SECTION 6 – PRESCRIPTION DRUGS

What this section includes answers to:

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

What Is My Prescription Drug Benefit?

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

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

How Do I Use My Prescription Drug Benefit?

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

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

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

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

Pharmacy Network

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

Some prescriptions have to be filled at a specialty pharmacy. You or your Provider must order these drugs directly from a Network specialty Pharmacy.

You can also get your prescriptions filled by a mail order Pharmacy. The mail order Pharmacy will fill your prescriptions and send them right to your home. The mail order Pharmacy is managed by our PBM. You can find more information about how to enroll on the Mail Order Drugs page on CareSource.com or by calling our PBM at 1-888-848-4452. You are not required to use the mail order Pharmacy.

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

Prescriptions for Eye Drops

Please note the timelines below if your Provider prescribes eye drops or topical ophthalmic products for you, and the prescription states that refills are needed. A Member can receive early refills as follows:

- After 21 days or more but before 30 days after receiving any 30-day supply of the product;
- After 42 days or more but before 60 days after receiving any 60-day supply of the product; or
- After 63 days or more but before 90 days after receiving any 90-day supply of the product.

If your prescription states that an additional bottle is needed for use in a day care center or school, your plan will also cover one (1) additional bottle.

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

How Does My Prescription Drug Benefit Work?

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

Your Prescription Drug Benefit only covers drugs and devices that are Medically Necessary. We will cover Medically Necessary drugs and devices that are used for purposes that have been approved by the U.S. Food and Drug Administration (FDA). We might also cover drugs and devices for uses that have not been approved by the FDA (off-label uses) if standard medical literature supports the use as both safe and effective. Both state and federal laws define what counts as standard medical literature. In order to be Medically Necessary, a drug must be provided at the most appropriate site and at the most appropriate level of care for your medical condition.

Your Prescription Drug Benefit will cover Medically Necessary treatments for preventive health, such as contraceptives and drugs to prevent HIV, for medical conditions, such as cancer, sickle cell disease, diabetes, hepatitis C, or hormone replacement, and for mental health conditions, such as major depressive

disorder, obsessive-compulsive disorder, schizophrenia, and gender dysphoria or gender incongruence.

Your Prescription Drug Formulary

Before going to your Provider's office or the Pharmacy to fill your prescription, you can look at the Prescription Drug Formulary (or just Formulary) to see if the drug is covered. The Formulary is available online at CareSource.com/Marketplace. We also have a search tool on our website where you can search for drugs. We can send you a printed copy of the Formulary if you call Member Services to ask for one; the phone number is listed on your ID Card.

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

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

Remember that you or your Provider can submit a request to bypass any of the limits listed above. You can find more information about how to request a bypass on our website at CareSource.com/plans/marketplace/benefits-services/pharmacy/preferred-drug-list/. If we deny one of

these requests, you may request an appeal (see Section 9: *Complaint Process, Claims Procedures, and Adverse Benefit Determination Appeals.*)

If you were already approved for a Prescription Drug for your condition, we will continue to cover it when your Provider says it is still Medically Necessary and other covered drugs are not right for you. This does not apply to uses that have not been approved by the U.S. Food and Drug Administration. Applicable Prescription Drug Cost, Benefit limits, allowed substitutions, and other Evidence of Coverage terms still apply.

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

- You must be eligible for coverage under the Plan,
- The drug/product must be a Covered Service,
- The drug/product does not exceed any applicable limits defined by the Formulary or in this EOC, and
- The drug/product may not be subject to an Exclusion under the Plan.

Please see Section 6: *Prescription Drugs*, *What Is Not Covered by My Prescription Drug Benefit* to learn more about what drugs and products are not covered by your Prescription Drug Benefit (subject to an Exclusion).

The Formulary is organized in levels called tiers. The tiers help you to know how much a drug may cost you. It includes Generic Drugs, preferred Brand-name Drugs, non-preferred Generic and Brand-name Drugs, and specialty drugs. Drugs in a higher tier cost more than drugs in a lower tier. You can find more information on the tiers in the Formulary.

Depending on your plan, your Deductible may apply to drugs in some tiers but not others. Your Schedule of Benefits will tell you the specific Copayment, Coinsurance, and Deductible details for your plan. Your Schedule of Benefits will also give you more details about how many days' worth of drugs you can get at a time and other similar limits. If you fill a quantity of a Covered drug for lower than the limit (for example, a drug filled for less than the typical 30-day supply) for the purpose of medication synchronization for a chronic condition, your prescription will still be Covered, but a Copayment, Coinsurance, and/or Deductible will apply.

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

- When you fill a prescription for a drug, you may pay less than your Copayment or Coinsurance if the cost of the drug for the pharmacy or the price that your plan and the pharmacy have agreed on is cheaper.
- Your cost is related to the days' supply of your prescription. You can usually fill for more than a one-month supply at a time only through your mail order pharmacy. Your total cost share will be discounted for prescriptions filled through mail order pharmacy. Refer to your Schedule of Benefits to see additional details. For more information about filling your prescriptions through mail order, you can call Member Services at the number on your ID Card or call the mail order pharmacy directly at 1-888-848-4452. Specialty drugs will be limited to a 30-day supply at a time.
- When your Plan covers a prescription for insulin, you will not pay more than $35 for a 30-day supply. This cost limit applies no matter what type of insulin you are prescribed or how much you need for a 30-day supply. You can check your Formulary to see which kinds of insulin your plan covers and if there are any limits. If you need insulin that is not included on the Formulary and your plan approves a Formulary exception request for it, this cost limit will still apply.

- Brand name drugs may not be covered if a generic for the same drug is available. If it is covered, it may cost you more than the generic would. Please note, for Brand-name Drugs that have an approved Generic, you may be required to pay the difference between the cost of the brand and the generic, in addition to your cost-share of the drug.
- You may use a copay card to get a discount on a drug that your plan covers. Copay cards will cover some of the Copayment or Coinsurance you have after your plan has paid for the drug. Drug manufacturers usually offer copay cards for expensive Brand-name Drugs up to a certain savings amount or number of fills. Any portion of the cost of a Prescription Drug that is paid, waived, or reimbursed by a pharmaceutical manufacturer or related entity may not be credited to your Deductible, Coinsurance, or Maximum Out-of-Pocket limit if a generic is available and/or if you are enrolled in an HDHP with an HSA. If you are enrolled in a Health Savings Account (HSA) Eligible Plan and use a copay card before your Deductible has been met, your tax savings for the HSA Eligible Plan with the Internal Revenue Service may be jeopardized.
- When your plan approves a request to cover a non-Formulary drug, you will pay the highest applicable cost-share.
- You may be treating cancer with a drug that you can give to yourself orally, such as a pill or tablet. If so, your cost share will not be more than $100 per prescription unless the Deductible applies while you are in a High Deductible Health Plan (HDHP). Additionally, the Copayment, Coinsurance, or Deductible that applies to the oral drug will not be more than the Copayment, Coinsurance, or Deductible that applies to a drug your provider would have to give you such as an injection or infusion.

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

The P&T Committee looks at your Formulary regularly to make sure it is up-to-date. We may change your Formulary based on the decisions of the P&T Committee. You can always find the most up-to-date Formulary by using the search tool on our website, or by calling Member Services to ask for a printed copy. The P&T Committee will not remove drugs from the Formulary or move them to a higher tier during the plan year except when a Brand-name Drug has a new Generic alternative. During open enrollment, we will post a notice on our website of all the drugs that will be removed for the next plan year.

Timing of Prescription Drug Request Determinations

Type	Standard Request	Expedited (urgent) Request
Formulary	72 hours	24 hours
Formulary Step Therapy	2 business days	24 hours
Non-Formulary	72 hours	24 hours

Drug Exception (Non-Formulary Drug) Process

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

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

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

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

Next Level of Review for a Non-Formulary Drug Determination

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

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

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

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

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

Timing of Medical Drug Request Determinations

Type	Timeframe for Making a Decision
Expedited (urgent) request	72 hours
Standard request	15 calendar days
Retrospective request	30 calendar days

Our Pharmacy Benefit Manager

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

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

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

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

Medication Therapy Management Program

At CareSource, we believe it is critical that you take your medications correctly and are on the right medications for your health conditions. We offer the medication therapy management program (MTM) as a free program to help you do just that. We encourage you to meet with a participating pharmacist and discuss your medications.

Opioid Analgesics and Controlled Substances

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

At any time, your Prescription Drug Benefit includes treatments to help you safely withdraw from Substance Use Disorder or to treat opioid use disorder. These treatments are not subject to limitation and include those prescribed by a pharmacist.

What Is Not Covered by My Prescription Drug Benefit?

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

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

- Drugs or devices that are not on the Prescription Drug Formulary and that do not meet all requirements for clinical appropriateness;
- Drugs or devices that are not approved by the U.S. Food and Drug Administration (FDA);
- Drugs or devices that have been dispensed to you with a date of service outside of your coverage eligibility;
- Drugs or devices that are for any condition, Injury, Sickness or Behavioral Health Disorder arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a Claim for such benefits is made or payment or benefits are received;
- Drugs or devices for which payment or benefits are provided or available from the local, state, or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
- Drugs or devices that are covered under your Medical Benefit (see Section 5: *Your Covered Services*);
- Drugs or devices that are available over-the-counter (OTC) and do not require a prescription order or refill by law before being dispensed unless:
  - The plan has designated the OTC drug or device as eligible for coverage as if it were a prescription drug, or the OTC drug or device is classified as a Preventive Health Care Service, AND
  - The OTC drug or device is obtained with a prescription order from a provider; AND
  - The OTC drug or device is available on the Prescription Drug Formulary;
- Prescription Drugs that are available in over-the-counter form or are comprised of components that are available in over-the-counter form or equivalent. This Exclusion does not apply to over-the-counter products that the Plan is required to cover under federal law that are mandated as a Preventive Health Care Service;
- Certain prescription drugs that the Plan has determined are therapeutically equivalent to an over-the-counter drug. This exclusion does not apply to over-the-counter products that the Plan is required to cover under federal law that are mandated as a Preventive Health Care Service;
- Compounded drugs that contain any ingredient(s) that have not been approved by the FDA and/or that are not on the Prescription Drug Formulary and that require a prescription order or refill;
- Compounded drugs that are commercially available in a different form to treat the same disorder, unless the compounded dosage form and its components meet all standards of Medical Necessity and contains covered Drugs that cannot be administered through another commercially available product. (Compounded drugs that contain only covered ingredients that require a prescription order or refill are assigned to the highest applicable cost-share);
- Drugs or devices that are dispensed by a Pharmacy that is a Non-Network Provider;
- Drugs or devices that are dispensed outside of the United States, unless dispensed as part of Emergency Medical Services or Urgent Care Services;
- Durable Medical Equipment (prescribed and non-prescribed Outpatient supplies, other than those specifically stated as covered on the Prescription Drug Formulary);
- Drugs or devices that are prescribed, dispensed, or intended for use during an Inpatient Stay;
- Drugs or devices that are prescribed, dispensed, or intended for use during a Skilled Nursing Stay;
- Drugs or devices that are prescribed for any of the following as a primary diagnosis:
  - Appetite suppression or weight loss
  - Cosmetic procedures or purposes (such as wrinkles or male pattern baldness)
  - Hyperhidrosis

  - Onychomycosis
  - Sexual dysfunction
- Prescription Drugs, including new Prescription Drugs or new dosage forms, that CareSource determines do not meet the definition of a Covered Service;
- Prescription Drugs that contain an active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug;
- Drugs or devices that are typically administered by a qualified Provider or licensed health professional in an Outpatient setting. This Exclusion does not apply to Depo Provera and other injectable drugs used for contraception which may be covered according to the Prescription Drug Formulary;
- Drugs or devices that are used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless CareSource has agreed to cover an Experimental or Investigational or Unproven Service, as defined in Section 2: *Definitions*;
- Growth hormone therapy used to treat familial short stature. (This Exclusion does not apply to growth hormone therapy which is Medically Necessary, as determined by CareSource, to treat a diagnosed medical condition other than familial short stature);
- Fertility drugs unless used to treat the medical condition that results in infertility; and
- Drugs considered to be natural or homeopathic remedies, medical foods, herbal remedies or supplements, naturopathic therapies, complementary medicines, or alternative medicines.

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

SECTION 7 – WHAT IS NOT COVERED

This section includes information on:

- Exclusions; and
- Limitations

Benefit Limitations

Benefit limits are listed in your Schedule of Benefits or Section 5: *Your Covered Services*. Limitations may also apply to some Covered Services that fall under more than one Covered Service category. Please review all limits carefully. We will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits. When we say "this includes" or "including," it is not our intent to limit the description to that specific list, but, rather, to provide examples. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

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

Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section. All Exclusions listed in this section apply to you. The services, treatments, items or supplies listed in this section are not Covered Services unless they are listed as a Covered Service in Section 5: *Your Covered Services* or through a Rider/Enhancement or Amendment to this EOC.

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

- Any Health Care Service that is not an Essential Health Benefit unless it is listed as a Covered Service in this Evidence of Coverage, through a Rider/Enhancement, or Amendment to this EOC, unless otherwise required by law or regulation.
- 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, Investigational, or Unproven 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, Investigational, or Unproven Service. Please refer to the Experimental, Investigational, or Unproven Services Exclusion section, below, for further information on how we determine whether a service is Experimental, Investigational, or Unproven.
- Received to treat any condition, disease, defect, ailment, or Injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this Exclusion does not apply. This Exclusion applies if you receive Workers' Compensation Act benefits in whole or in part. This Exclusion also applies whether or not you Claim the benefits or compensation. It also applies

whether or not you recover compensation from any Third Party.

- Provided to you as benefits by any governmental unit, unless otherwise required by law or regulation.
- Received to treat any Sickness or Injury that occurs while serving in the armed forces.
- Received to treat a condition resulting from direct participation in an act of terrorism, a riot, and/or civil disobedience, or resulting from exposure to a nuclear explosion, and/or nuclear accident.
- For court ordered testing or care unless Medically Necessary.
- Health Care Services 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.
- Services performed by a Provider who is a family member by birth, marriage, or ordinarily resides in the Member's home. Examples include but are not limited to a spouse, brother, sister, parent, or child. This includes any service the Provider may perform on himself or herself.
- For completion of Claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For any travel related expenses, except as authorized by us or specifically stated as a Covered Service in Section 5: *Your Covered Services, Transplant: Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services*.
- 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 other than Basic 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.
- Chemonucleolysis.
- Biliary lithotripsy.
- Gene therapy, cell therapy, cell-based gene therapy, including Chimeric Antigen Receptor (CAR) T-cell therapy and/or gene therapy, allogenic processes, glandular organs, and any related health Care Services as well as any future therapies within these drug groups.
- Charges for the following:
  - 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.
  - 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.
  - Long-term / custodial nursing home care.
  - 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 routine foot care if for palliative or cosmetic reasons, including the cutting or removing of corns and calluses; nail trimming, cutting or debriding, hygienic and preventive maintenance foot care, including:
  - Cleaning and soaking the feet.
  - Applying skin creams in order to maintain skin tone.
  - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.
  - This exclusion does not apply to routine foot care that is Medically Necessary and prescribed by a Physician.
- For weight loss programs unless specifically listed as covered in this EOC. This Exclusion includes commercial weight loss programs and fasting programs.
- For marital counseling.
- For biofeedback.
- For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service in Section 5: *Your Covered Services.*
- For vision orthoptic training except as otherwise specifically stated as a Covered Service in Section 5: *Your Covered Services.*
- For hearing aids or examinations to prescribe or fit them, unless otherwise specified within Section 5: *Your Covered Services.*
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- For Health Care Services and associated expenses for Assisted Reproductive Technology (ART) including in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures other than those described in this EOC. This includes any related prescription medication treatment; embryo transport; donor ovum and semen and related costs, including collection and preparation.

- For cryo-preservation and other forms of preservation of reproductive materials.
- For long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
- For Health Care Services related to surrogacy if the Covered Person is not the surrogate.
- For workplace/hiring physicals.
- 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 except as otherwise stated;
  - Purchase or rental of supplies for common household use, such as water purifiers;
  - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
  - 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. If your plan includes the Adult Vision and Fitness Rider/Enhancement, see your Rider details for exceptions.
- For telephone consultations or consultations via electronic mail or web site, except as required by law, authorized by us, or as otherwise described in this EOC.
- For Health Care Services received in an Emergency Room which are not Emergency Medical Services, except as specified in this EOC. This includes but is not limited to suture removal in an Emergency Room.
- 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, except when a standby Physician is required to assist with certain specified high-risk services for such time Physician is in immediate proximity to the patient.
- For physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes; this Exclusion shall not apply to those Health Care Services for which Benefits have not been exhausted or that have not been covered by another source.
- For private duty nursing services rendered in a Hospital or Skilled Nursing Facility. Private duty nursing services are Covered Services only when provided through the Home Health Care Services Benefit as specifically stated in Section 5: *Your Covered Services, Home Health Care Services*.
- For services and supplies related to the primary diagnosis of male or female sexual or erectile dysfunction or inadequacies. This exclusion includes sexual therapy and counseling, penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of a primary diagnosis of impotency, and all related diagnostic services.
- For services or supplies related to alternative or complementary medicine. Services in this category include but are not limited to acupuncture, aroma therapy, Auditory Integration Therapy (AIT), Bio-Energetic Synchronization Technique (BEST), colonic irrigation, contact reflex analysis, dietary, herbal, or vitamin products or therapies, electromagnetic therapy, holistic medicine, homeopathy, hypnosis, iridology(study of the iris), light fixtures or sun lamps for treatment of Seasonal Affective Disorder (SAD), magnetic innervation therapy, massage and massage therapy,

naturopathy, neurofeedback, orthomolecular therapy, prolotherapy, reiki therapy, sensory integration therapy, sleep therapy, and thermograph, .

- For any services or supplies provided to a person not covered under this EOC in connection with a surrogate Pregnancy.
- For treatment of hyperhidrosis (excessive sweating).
- For human growth hormone for children born small for gestational age.
- For drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are Therapeutically Equivalent to an over the counter drug, device, product, or supply. This exclusion shall not apply to drugs prescribed as Preventive Health Care Services.
- For sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
- For treatment of telangiectatic dermal veins (spider veins) by any method.
- For nutritional and/or dietary supplements, except as provided in this EOC or as required by law. This Exclusion includes: those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed Pharmacist.
- For Health Care Services you receive outside of the United States other than Emergency Medical Services or Urgent Care Services.
- Received if the Injury, Illness, or Sickness for which the Health Care Services are rendered resulted from an action or omission for which a governmental entity is liable.
- For dental services unless specified in this EOC.
- For neuropsychological testing when not considered Medically Necessary.
- For cardiac rehabilitation services provided on a non-monitored basis and treatment for intellectual disability.

Experimental, Investigational, or Unproven Services Exclusion

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

We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental, Investigational, or Unproven 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, Investigational, or Unproven, 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, Investigational, or Unproven based on the criteria above may still be deemed Experimental, Investigational, or Unproven by us. In determining whether a Health Care Service is Experimental, Investigational, or Unproven, 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, Investigational, or Unproven under the above criteria may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the United States Food and Drug Administration or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Documents of an institutional review board or other similar body performing substantially the same function; or
- Consent document(s) and/or the written protocol(s) used by your Providers studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

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

SECTION 8 – STAYING HEALTHY

Healthy Living/Care and Disease Management Programs

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

What this section includes:

Health and well-being resources available to you, including:

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

CareSource believes in giving you the tools you need to be an educated health care consumer. We have several convenient educational and support services, accessible at CareSource.com, to help you take care of yourself, manage a chronic health condition, and navigate the complexities of the health care system.

Note:

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

24-Hour Nurse Advice Line

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

Integrated Care Management

If you have a serious or complicated health problem or want to learn more about your acute or chronic illness, we are here to help you navigate through the health care system to get the coordinated, quality care you need. Our experienced care management team works with you and your doctor to make certain you are getting the best care possible. We do the coordination for you so that you can concentrate on your health. In addition, our care management team can assist you with finding resources to support you and improving your overall health.

Reminder Programs

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

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

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

CareSource Online

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

On our website, you can:

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

CareSource MyLife: Your Personalized Health Companion

Available on any device, CareSource MyLife℠ lets you manage your health plan while getting support in your daily health journey. CareSource MyLife lets you:

- Start your personalized health journey
  - Receive care in your daily health journey
  - Get insights that fit your unique health needs.
- Access your account anytime, anywhere
  - Use it as a mobile app, so you can manage your health on the go.
  - Use it from any device
- Manage your health plan
  - Take care of your health plan and your dependents' plans all in one place.
- Discover helpful resources
  - Find additional benefits and resources included in your health plan.

Visit MyLife.CareSource.com. Or get it through the App Store® or Google Play®.

SECTION 9 – 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 1-833-230-2099 with any questions you have about your Benefits, including any questions about your coverage and Benefit levels, Annual Deductibles, Coinsurance, Copayment and Annual Out-of-Pocket Maximum amounts, specific claims or services you have received, our Network, and our authorization requirements.

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

The Complaint Process

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

You, or an Authorized Representative, including your Provider, may submit your complaint by sending a letter to us at the following address: CareSource, Attention: Nevada Member Appeals, P.O. Box 1947, Dayton, OH 45401, or by submitting your complaint through your personal online account at MyLife.CareSource.com.

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

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

Definitions

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

Adverse Benefit Determination means a determination by CareSource that an admission, availability of care, continued stay or other Health Care Service that is a covered Benefit has been reviewed and, based upon the information provided, does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

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

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

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

Final Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by us at the completion of the Internal Appeals process described in this section.

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

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

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

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

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

Internal Appeal Process

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

Adverse Benefit Determination Appeals

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

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

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

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

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

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

Standard Review of an Internal Appeal

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

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

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

We will notify you of our Final Adverse Benefit Determination within thirty (30) calendar days after receiving the completed Internal Appeal.

If we deny your Internal Appeal, we will notify you via a Final Adverse Benefit Determination notice.

If we approve your request for benefits, then we will provide you, your attending Physician, or ordering Provider with the appropriate notice.

Expedited Review of an Internal Appeal

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

- Any request for Health Care Services when the time periods for making non-Urgent Care Review determinations:
  - Could seriously jeopardize your life or health or your ability to regain maximum function.
  - 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 request.
  - Except as provided below, whether a request meets the above conditions in order to be eligible for an expedited Internal Appeal will be determined by an individual acting on behalf of CareSource applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine.
- Any request that a Physician with knowledge of your medical condition determines is a request involving Urgent Care Services.

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

If the expedited clinical appeal fails to meet expedited criteria, you or your Authorized Representative will be contacted via telephone and in writing advising that the matter does not meet expedited criteria and will be handled under the standard Internal Appeal process. However, if your Physician with knowledge of your condition indicates that the appeal must be processed as expedited, CareSource will render an expedited decision.

We will complete an expedited review of an Internal Appeal as soon as possible given your medical needs, but no 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 the same or similar information to that provided in a notice of non-expedited Internal Appeal. If we approve your request for Benefits, we will also provide you, your attending Physician, or ordering Provider with the appropriate written notice.

Exhaustion of the Internal Appeals Process

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

- We agree to waive the exhaustion requirement.
- You did not receive a written decision of the Internal Appeal within the required time frame.
- We failed to meet all requirements of the Internal Appeal process.
- An expedited External Review is sought simultaneously with an expedited Internal Appeal.

External Review Process

Members have the right to request an External Review of an Adverse Benefit Determination notice. The Member or the Member's Authorized Representative may submit a request directly to the Office for Consumer Health Assistance (OCHA) for an External Review of an Adverse Determination by an Independent Review Organization (IRO). Requests for an External Review must be made in writing within four (4) months of the date of the notice of Adverse Benefit Determination or Final Adverse Benefit Determination. Members can submit a written request for External Review along with any supporting documentation, to the Office for Consumer Health Assistance (OCHA) at 7150 Pollock Drive Las Vegas, NV 89119, 1-888-333-1597.

The determination of an IRO concerning an External Review in favor of the Member is final, conclusive, and binding. Upon receipt of the decision by the IRO reversing an Adverse Determination, the Plan will immediately approve the coverage of the health care service or treatment that was the subject of the Adverse Determination.

External Review – Experimental/Investigational Denials

For denials based on Experimental or Investigational determinations, the Covered Person or Authorized Representative may request External Review within four (4) months of the Adverse Determination.

An expedited External Review may be requested orally or in writing if the treating Physician certifies that delay would significantly reduce the effectiveness of the requested service.

Upon request, the Plan will promptly determine eligibility and notify the Covered Person and the OCHA. If deemed ineligible, the notice will include the reason and the right to appeal to OCHA. OCHA may override the Plan's eligibility determination. If eligible, OCHA will assign an Independent Review

Organization (IRO). The Plan will provide all required documentation. Expedited reviews will be completed as quickly as the medical condition requires but no later than five (5) calendar days.

If the IRO reverses the Adverse Determination, coverage will be approved immediately.

Standard External Review

Within five (5) days after OCHA receives the request for External Review, OCHA will notify the Member and CareSource that the request was received and OCHA will assign an Independent Review Organization (IRO) to review the case.

Within five (5) days after receiving the notification specifying the assigned IRO from OCHA, the Plan will provide all documents and materials relating to the Adverse Determination to the assigned IRO. Within five (5) days after the IRO receives the required documentation from CareSource, the IRO will notify the Member, the Member's Physician, and CareSource if any additional information is required to conduct a review of the Adverse Benefit Determination. If additional information is required, it must be provided to the IRO within five (5) days after receiving the request. The IRO will forward a copy of any additional information received from the Member or the Member's Physician to CareSource within one (1) business day after receipt.

The IRO will approve, modify, or reverse the Adverse Determination within fifteen (15) days after it receives the information required to make the determination. The IRO will notify the Member, the Member's Authorized Representative, the Member's Physician, and CareSource of its determination and the reason for its determination.

Expedited External Review

OCHA will approve or deny a request to expedite an External Review of an Adverse Determination no later than 72 hours after it receives proof from the Provider that the Adverse Determination concerns an admission, availability of care, continued stay or health care service for which the Member received Emergency Medical Services but has not been discharged from the Facility providing the services or care; or failure to proceed in an expedited manner may jeopardize the life or health of the Member or their ability to regain maximum function.

If OCHA approves the case to be handled in an expedited manner, OCHA will assign the request to an IRO within one (1) Business Day of approving the request. CareSource will provide all documents and materials to the IRO within twenty-four (24) hours after receiving the notification from OCHA of the IRO assignment.

The IRO will complete the External Review no later than forty-eight (48) hours after receiving the assignment unless the Member and the Plan agree to a longer period. The IRO will notify all parties including the Member, Provider, and the Plan by telephone of its determination within twenty-four (24) hours of completing the External Review and send a written decision no later than forty-eight (48) hours after completing the External Review.

If You Have Questions About Your Rights or Need Assistance

You may contact us by mail or phone. Please call Member Services at 1-833-230-2099, or send correspondence to CareSource, Attention: Nevada Member Appeals, P.O. Box 1947, Dayton, OH 45401.

Language Services

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

SECTION 10 – COORDINATION OF BENEFITS (COB)

What this section includes:

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

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

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

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

Coordination of claims for services provided by an oral or maxillofacial surgeon which may be covered, in whole or in part, by a stand-alone dental benefit and a policy of health insurance: If the Member is covered by a stand-alone dental benefit and a policy of health insurance, the stand-alone dental benefit is the primary policy and the claim must be first submitted to the health insurer that issues the stand-alone dental benefit. The issuer of the secondary policy may not reduce benefits based upon payments under the primary policy, except to avoid overpayment to the oral and maxillofacial surgeon.

Definitions

A. "Health Plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Health Plan and there is no COB among those separate contracts.
   (1) Health Plan includes, as permitted by state law: group and nongroup insurance contracts, medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan.
   (2) Health Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage; auto insurance coverage; limited health benefit coverage; school accident type coverage covering grammar, high school, and college students for accident only; benefits for non-medical services in long-term care policies that pay a fixed daily benefit without regard to expenses incurred or the receipt of services in long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental Health Plans, unless otherwise permitted by law.

   Each contract for coverage under (1) or (2) is a separate Health Plan. If a Health Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate 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, andmay 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 the Primary Health Plan, it determines payment for its Benefits first before those of any other Health Plan without considering any other Health Plan's Benefits. When This Health Plan is the Secondary Health Plan, it determines its Benefits after those of another Health Plan and may reduce the Benefits it pays so that all Health Plan Benefits do not exceed the Primary Health Plan's Allowable Expense.

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

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

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
(2) If a person is covered by 2 or more Health Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
(3) If a person is covered by two (2) or more Health Plans that provide Benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
(4) If a person is covered by one Health Plan that calculates its Benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Health Plan that provides its benefits or services on the basis of negotiated fees, the Primary Health Plan's payment arrangement will be the Allowable Expense for all Health Plans. However, if the provider has contracted with the Secondary Health Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Health Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Health Plan to determine its Benefits.
(5) The amount of any benefit reduction by the Primary Health Plan because a Covered Person has failed to comply with the Health Plan provisions is not an Allowable Expense. Examples of these types of Health Plan provisions include second surgical opinions, precertification of admissions, and preferred Provider arrangements.

E. "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.

G. "Claim Determination Period" means a period of at least twelve (12) consecutive months, over which Allowable Expenses shall be compared with total Benefits payable in the absence of Coordination of Benefits, to determine whether over-insurance exists and how much each Health Plan will pay or provide.

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:

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

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

i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Health Plan of that parent has actual knowledge of those terms, that Health Plan is primary. This rule applies to Health Plan years commencing after the Health Plan is given notice of the court decree;
ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above will determine the order of Benefits;
iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of subparagraph (a) above shall determine the order of Benefits; or
iv. If there is no court decree allocating responsibility for the Dependent child's health care

expenses or health care coverage, the order of benefits for the child are as follows:

1. The Health Plan covering the Custodial Parent;
2. The Health Plan covering the spouse of the Custodial Parent;
3. The Health Plan covering the non-Custodial Parent; and then
4. The Health Plan covering the spouse of the non-Custodial Parent.

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

(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 D(1) can determine the order of Benefits.

(5) Longer or shorter length of coverage. If the preceding rules do not determine the order of benefits, the Health Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Health Plan and the Health Plan that covered the person the shorter period of time is the Secondary Health Plan.

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, we 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 calling Member Services. Please also refer to the appeals procedures listed in this EOC.

SECTION 11 – WHEN COVERAGE ENDS

What this section includes:

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

Guaranteed Renewable

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

- You are no longer eligible for coverage under the Plan through the Marketplace.
- You do not pay your Premium on time provided that the applicable Grace Period set forth in Section 3: *How the Plan Works* has been exhausted.
- You commit an act, practice of omission that constitutes Fraud.
- You commit an intentional misrepresentation of material fact.
- You change coverage to another Qualified Health Plan during an open or special enrollment period.
- CareSource terminates or is decertified by the Marketplace.
- You obtain other minimum essential coverage.
- You no longer reside in our Service Area.

If you enrolled in the Plan through the Marketplace, then you may terminate coverage under this Plan by providing at least fourteen (14) calendar days prior notice to the Marketplace. To request termination through the Marketplace, you can login to your Marketplace account nevadahealthlink.com or contact the Marketplace at 1-800-547-2927. The termination effective date may be effective as soon as fourteen (14) days from the date that you request termination, unless otherwise agreed upon. Retroactive termination requests will be processed in accordance with 45 C.F.R. § 155.430.

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

If we discontinue offering a particular type of Plan, you will be notified at least ninety (90) days before the date of discontinuation or one hundred and eighty (180) days for a complete withdrawal, and you will be given the opportunity to purchase another Plan currently being offered by us. If you are renewed into the same plan with altered terms, we will notify you of changes at least thirty (30) days prior to open enrollment.

Notice of Termination and Date of Termination

The Marketplace and the Plan will notify you if your coverage ends at least sixty (60) calendar days prior to the last day of coverage, with such effective date determined by the Marketplace in accordance with 45 C.F.R. §155.430(d) when applicable. Where the coverage end is retroactive or less than thirty (30) days from the date we are made aware, we will notify you within thirty (30) calendar days of us being made aware. The notice will set forth the reason for the termination and will tell you the date your coverage under the Plan

ends. If you are delinquent on premium payment, we will provide you with notice of such payment delinquency. If your coverage is cancelled, we will return to you any unearned portion of premiums you paid beyond the month in which the cancellation is effective.

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

Reinstatement

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

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

Benefits after Termination

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

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

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

Note**:** In the event that we terminate your coverage while you are receiving Inpatient Services in a Hospital as a result of our insolvency or end of operations, a Network Provider may not bill you for Covered Services provided in accordance with the terms of this EOC. However, a Network Provider may bill you for

applicable Copayments, Coinsurance and Deductible amounts.

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 ifthe underlying medical condition occurred before your coverage ended.

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

Rescission

Under certain circumstances, we may take away your coverage under the Plan. A Rescission of your coverage means that the coverage may be legally voided retroactive to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes Fraud; or unless you (or a person seeking coverage on your behalf) make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an Internal Appeal of a Rescission of your coverage. Once the Internal Appeal process is exhausted, you have the additional right to request an independent External Review. See Section 9: *Complaint Process, Claims Procedures, and Adverse Benefit Determination Appeals* for more information.

Certification of Prior Creditable Coverage

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

SECTION 12 – OTHER IMPORTANT INFORMATION

What this section includes:

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

No Waiting Periods or Pre-Existing Conditions

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

No Lifetime Limits on the Dollar Value of Essential Health Benefits

The Plan does not impose any lifetime limits on the dollar amount of Essential Health Benefits, as defined in Section 2: *Definitions*, covered under this Plan.

No Annual Limits on the Dollar Value of Essential Health Benefits

The Plan does not impose any annual limits on the dollar amount of Essential Health Benefits, as defined in Section 2: *Definitions*, covered under this Plan.

Your Relationship with CareSource

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

- CareSource does not recommend what Health Care Services you need or will receive. You and your Physician make those decisions.
- CareSource communicates to you decisions about whether 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.
- We may not pay for all Health Care Services you or your Physician may believe are necessary.

CareSource's Relationship with Providers

The relationships between CareSource and Network Providers are contractual relationships between independent contractors. Network Providers are neither CareSource's agents nor employees. CareSource and any of its employees are neither agents nor employees of Network Providers. CareSource does not provide Health Care Services or supplies, nor does CareSource practice medicine. Instead, CareSource arranges for Providers to participate in a Network. CareSource also pays Benefits. Network Providers are independent practitioners who run their own offices and Facilities. CareSource's credentialing process confirms public information about the Providers' licenses and other credentials but does not assure the quality of the Health Care Services provided. Providers are not CareSource's employees. CareSource does not have any other relationship with Network Providers such as principal-agent or joint venture. CareSource is not liable for any act or omission of any Provider.

Your Relationship with Providers

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

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

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

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

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

Interpretation of Benefits

CareSource has the sole authority to:

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

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

Guaranteed Availability and Renewability

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

while the Plan is in effect.

Claims

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

Notice of Claim

Written notice of a Claim must be given to us within sixty (60) days after the occurrence or commencement of any loss covered by the Plan, or as soon as thereafter as is reasonably possible. Notice given by you or an Authorized Representative to CareSource at Attn: Claims Department P.O. Box 36 Dayton, OH 45401-0036, or to any authorized agent of CareSource, with information sufficient to identify the insured, shall be deemed notice to us.

Claim Forms

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

Proof of Loss

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

Many Providers may file Claims for you. If your Provider will not file a Claim, and you do not receive a Claim form from us within fifteen (15) days of our receipt of notice of Claim, you may submit a written notice of services rendered to us without the Claim form. The same information that would be given on the Claim form must be included in the written proof of loss. This includes the name of the Covered Person, relationship to you, identification number, date, type and place of service, your signature and the Provider's signature be fully discharged from that portion of its liability. Proof of Loss shall be submitted to us at: CareSource Attn: Claims Department P.O. Box 36 Dayton, OH 45401-0036.

Payment of Benefits

We will pay or deny a Claim within twenty-one (21) days for electronic claims or within thirty (30) days for non-electronic claims after we receive a Claim that includes all of the information necessary to process the Claim. If additional information is required to determine whether to approve or deny the Claim, we will notify the applicable person within twenty (20) working days after receiving the Claim. We will tell the applicable person the type of supporting information needed. We will pay or deny the Claim within twenty-one (21) days after receiving the additional information if it was submitted electronically, or thirty (30) days

after receiving the additional supporting documentation if it was not submitted electronically. We will pend claims for APTC eligible members if those members are APTC eligible and fall into the grace period. 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.

Payments for treatment relating to mental health or an alcohol or Substance Use Disorder must be paid directly to the Provider if the Provider is a Non-Network Provider and has a written assignment of Benefits.

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.

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.

Explanation of Benefits

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

Legal Action

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

Information and Records

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

Incentives to Providers

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

Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality measures, Covered Person satisfaction, and/or cost-effectiveness; or
- A practice called capitation, which is when a group of Network Providers receives a monthly payment from CareSource for each Covered Person who selects a Network Provider within the

group to perform or coordinate certain Health Care Services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

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

Incentives to You

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

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.

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for equality in the insurance coverage, treatment limits and financial coverage, of behavioral health/Substance Use Disorder benefits and medical/surgical benefits. Generally, a plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on behavioral health and Substance Use Disorder benefits.

Additionally, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on behavioral health and Substance Use Disorder benefits that are more restrictive than those applicable to other medical/surgical benefits.

Women's Health and Cancer Rights Act Notice

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

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

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

Domestic Violence

We will not deny a claim, refuse to issue a policy or cancel a policy solely because the claim involves an act that constitutes domestic violence pursuant to NRS 33.018, or because the person applying for or covered by the policy was the victim of such an act of domestic violence, regardless of whether the Member or applicant contributed to any loss or injury.

Intoxicated or Under the Influence

We will not deny a claim, refuse to issue a policy or cancel a policy solely because the applicant or insured was intoxicated or under the influence of a controlled substance.

Physical Examination and Autopsy

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

Genetic Screening

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

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

Legal Contract

This EOC, any Riders/Enhancements, Attachments, including the Schedule of Benefits, Amendments, and documentation submitted to the Marketplace and CareSource, constitute the entire legal contract between you and CareSource, and as of the effective date of your coverage, supersede all other agreements between us. This EOC, its Riders/Enhancements, and Amendments constitute the legal contract between CareSource

and you. Your payment of the first Premium owed to us and your receipt of Benefits under the Plan indicate your acceptance of andagreement with the terms and conditions of this EOC, its Riders/Enhancements, and Amendments. Any and all statements that you have made to us and any and all statements that we have made to you are representations and not warranties. No such statement, unless it is contained in this EOC and any of its Riders/Enhancements or Amendments, will be used in defense to a Claim under this EOC, its Riders/Enhancements, or Amendments.

Medicare

Any Health Care Services covered under both this Plan and Medicare will be paid according to Medicare secondary payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines. As a Medicare secondary payor, benefits under this Plan shall be determined after those of Medicare.

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

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

This Plan is not a Medicare supplemental policy. If you are eligible for Medicare, please review the “Guide to Health Insurance for People with Medicare” available from CareSource or at medicare.gov/publications.

Changes/Amendments

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

Misstatement of Information

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

Non-Discrimination

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

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio,

accessible electronic formats, other formats). In addition, CareSource provides free language services to people whose primary language is not English, such as qualified interpreters, and information written in other languages. If you need these services, please contact CareSource at 1-833-230-2099 TTY: 711.

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room
509F HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

Member No Surprises Act Protections

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

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

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

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

- Timely notify each Member of the termination and their right to elect continued transitional care from the Provider or Facility;

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

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

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

You can also call Member Services for assistance.

Conformity with Law

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

Severability

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

Waiver and Oral Statements

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

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

Non-Assignment

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

Clerical Errors

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

Circumstances Beyond Our Control

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

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

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

Express Consent to be Contacted

By providing your contact information to the Marketplace and/or CareSource during the application and enrollment process and at any other time, you expressly consent and agree that CareSource and its affiliates, agents and service providers may contact you by any or all of the following: manual calling methods, prerecorded or artificial voice messages, text messages, written correspondence, emails and/or automatic telephone dialing systems. You agree that CareSource and its affiliates, agents and service providers may use any email address and any telephone number, including a number for a cellular phone or other wireless device, you provide now or in the future to the Marketplace and/or CareSource and its affiliates, agents and service providers to contact you.

Time Limit on Certain Defenses

After three (3) years from the date of issue of this EOC no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the EOC 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 EOC 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 EOC, we may contest coverage under the EOC 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 EOC was reinstated.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding CareSource's standards for the collection, use, and disclosure of information gathered in connection with our business activities.

- We may collect personal information about a Covered Person from persons or entities other than the Covered Person.
- We may disclose Covered Person information to persons or entities outside of CareSource without Covered Person authorization in certain circumstances.
- A Covered Person has a right of access and correction with respect to all personal information collected by us.
- A more detailed notice will be furnished to you upon request.

This Evidence of Coverage and Health Insurance Contract (EOC) constitutes a contract between you and CareSource for the Plan. This EOC takes the place of any other issued to you by CareSource on a prior date.

This EOC is delivered in and governed by the laws of Nevada. All coverage under this Plan shall begin at 12:00 midnight and shall end at 11:59:59 Eastern Standard Time.

Erhardt H. Preitauer
President and Chief Executive Officer
CareSource Nevada Co.

Get free help in your language with interpreters and other written materials. Get free aids and support if you have a disability. Call **1-833-230-2099** (TTY: 711).

Obtenga ayuda gratuita en su idioma a través de intérpretes y otros materiales en formato escrito. Obtenga ayudas y apoyo gratuitos si tiene una discapacidad. Llame al: **1-833-230-2099** (TTY: 711).

Jwenn èd gratis nan lang ou ak entèprèt ansanm ak lòt materyèl ekri. Jwenn èd ak sipò gratis si w gen yon andikap. Rele **1-833-230-2099** (TTY: 711).

احصل على مساعدة مجانية بلغتك من خلال المترجمين الفوريين والمواد المكتوبة الأخرى. إذا كنت من ذوي الاحتياجات الخاصة، ستحصل على المساعدات والدعم مجانًا. اتصل على الرقم **1-833-230-2099** (TTY "الهاتف النصيّ للصم وضعاف السمع": 711).

通过口译员和其他书面材料，获得您所使用语言的免费帮助。 如果您有残疾，可以获得免费的辅助设备和支持。 请致电：**1-833-230-2099**（听语障人士专用电话：711）。

Erhalten Sie kostenlose Hilfe in Ihrer Sprache durch Dolmetscher und andere schriftliche Unterlagen. Beziehen Sie kostenlose Hilfsmittel und Unterstützung, wenn Sie eine Behinderung haben. Rufen Sie folgende Telefonnummer an: **1-833-230-2099** (TTY: 711).

Obtenez une aide gratuite dans votre langue grâce à des interprètes et à d’autres documents écrits. Si vous souffrez d’un handicap, vous bénéficiez d’aides et d’assistance gratuites. Appelez le **1-833-230-2099** (ATS : 711).

Nhận trợ giúp miễn phí bằng ngôn ngữ của quý vị với thông dịch viên và các tài liệu bằng văn bản khác. Nhận trợ giúp và hỗ trợ miễn phí nếu quý vị bị khuyết tật. Gọi **1-833-230-2099** (TTY: 711).

Grick Helfe mitaus Koscht in dei Schprooch mit Iwwersetzer un annere schriftliche Dinge. Grick Aids un Helfe mitaus Koscht wann du en Behinderung hoscht. Ruf **1-833-230-2099** (TTY: 711).

आपकी भाषा के इंटरप्रेटर तथा आपकी भाषा में अन्य लिखित सामग्रियों संबंधी फ्री मदद पाएं। यदि आपको कोई डिसएबिलिटी हो, तो मुफ्त सहायता और सपोर्ट प्राप्त करें। कॉल करें **1-833-230-2099** (TTY: 711).

통역사와 기타 서면 자료의 도움을 귀하의 언어로 무료로 받으세요. 장애가 있을 경우, 보조와 지원을 무료로 받으세요. **1-833-230-2099** (TTY: 711) 로 문의하세요.

በአስተርጓሚዎች እና በሌሎች የጽሑፍ ቁሳቁሶች በቋንቋዎ ከክፍያ ነፃ እርዳታ ያግኙ። የአካል ጉዳት ካለብዎት ከክፍያ ነፃ እርዳታ እና ድጋፍ ያግኙ። ወደ **1-833-230-2099** (TTY 711) ይደውሉ።

Gba ìrànlọ́wọ́ ọ̀fẹ́ ní èdè rẹ pèlú àwọn ògbifọ̀ àti àwọn ohun èlò míràn tí a kọ sílẹ̀. Gba àwọn ìrànlọ́wọ́ àti àtilẹ́yìn ọ̀fẹ́ bí o bá ní àìlera kan. Pe **1-833-230-2099** (TTY: 711).

Makakuha ng libreng tulong sa wika mo gamit ang mga interpreter at mga ibang nakasulat na materyales. Makakuha ng mga libreng pantulong at suporta kung may kapansanan ka. Tumawag sa **1-833-230-2099** (TTY: 711).

په خپله ژبه کې د ژباړونکو او نورو لیکلي شوو موادو له لارې وړیا مرسته ترلاسه کړئ. که تاسو معلولیت لرئ نو وړیا ملاتړ او مرستې ترلاسه کړئ. دې شمېرې ته زنګ ووهئ **1-833-230-2099** (TTY: 711).

వ్యాఖ్యాతలు మరియు ఇతర రాతపూర్వక మెటీరియల్స్‌తో మీ భాషలో ఉచిత సహాయాన్ని పొందండి**.** ఒకవేళ మీకు వైకల్యం ఉంటే**,** ఉచిత ఉపకరణాలు మరియు మద్దతు పొందండి**.** కాల్ చేయండి**:1-833-230-2099** (TTY: 711).

दोभाषे र अन्य लिखित सामग्रीहरूको माध्यमद्वारा आफ्नो भाषामा निःशुल्क मद्दत प्राप्त गर्नुहोस्। तपाईंलाई अशक्तता छ भने निःशुल्क सहायता र समर्थन प्राप्त गर्नुहोस्। **1-833-230-2099** (TTY: 711) मा कल गर्नुहोस्।

သင့်ဘာသာစကားအတွက် စကားပြန်များနှင့် အခြားပုံနှိပ်စာရွက်များကို အခမဲ့အကူအညီရယူပါ။ သင်သည် မသန်စွမ်းသူတစ်ဦးဖြစ်ပါက အခမဲ့အကူအညီများနှင့် အထောက်အပံ့များ ရယူပါ။ ဖုန်းခေါ်ရန် - **1-833-230-2099** (TTY: 711)

Bōk jibañ ilo an ejjelok wōnāān ikkijjien kajin eo am ibbān rukok ro im wāween ko jet ilo jeje. Bōk jerbalin jibañ ko ilo an ejjelok wōnāer im jibañ ko ñe ewōr am nañinmejin utamwe. Kalle **1-833-230-2099** (TTY: 711).

Multi-EXC-M-3287937