ANTIDOTE

Antidote Health Plan of Arizona, Inc.

Group Medical HMO Policy

1-xxx-xxx-xxxx
300 W. Clarendon Avenue, Suite 240
Phoenix AZ 85013

Effective Date: January 1, 2027

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SECTION I – INTRODUCTION

This document is Your Evidence of Coverage ("EOC") which outlines Your benefits, coverage details, Exclusions, and termination provisions under the Group Policy. Your EOC should be read together with Your Schedule of Benefits in order to understand the 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
- Deductible, Copayments, and Coinsurance payments required when You receive Covered Services.

Please carefully read and review the entire EOC. If You have any questions regarding the information contained within the document, You may contact Antidote online or via phone at the below telephone number.

As well, please review Section II – DEFINITIONS to ensure that You understand the words and defined terms that are incorporated throughout the EOC. These definitions will help assist You in understanding concepts, terminology, and meanings within the EOC.

Additionally, Antidote provides 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. Contact Member Services by calling the toll-free number on Your ID Card to request interpretation assistance. Antidote also sends and receives TDD/TTY messages using the National Relay Service by calling 711.

Further, whenever You have a question or concern regarding Your benefits, please call Member Services for clarification.

Also, note that some health services under Your Group's Policy are subject to Prior Authorization and approval before they may be covered. Please call Member Services to determine whether the service You will receive needs Prior Authorization from Antidote before payment will be made for the item/service. A list of services requiring Prior Authorization is also included in the Member Resources tab at antidotehealth.com. Your Provider is required to request Prior Authorization from Us.

For Emergency Services, Prior Authorization is not required and is covered regardless of whether the care is rendered by a Network Provider or Out-of-Network Provider, subject to the terms of this Policy.

Our Notice of Privacy Practices describes how We use and disclose protected health information. You can access Antidote's Notice of Privacy Practices on Our website at antidotehealth.com. You can also request a paper copy, at no cost to You, by calling Member Services at the number listed on the back of Your Antidote ID Card.

ANTIDOTE CONTACT INFORMATION:

Resource	Contact Information	Hours
Member Services Helpline	888-623-3195	Monday – Friday 7:00 AM to 1:00 AM Saturday and Sunday 8:00 AM to 1:00 AM
Urgent Care Helpline To assist You in locating an Urgent Care Network Provider, You may call Our Urgent Care Helpline for questions regarding Referrals to Network Providers that offer Urgent Care services and assistance with network exceptions. Urgent Care services received from a Network Provider do not require Prior Authorization. You may seek services from any Network Provider that offers such services without Prior Authorization. If You have any questions regarding Urgent Care, please call Our Urgent Care Helpline.	888-623-3195	Monday – Friday 7:00 AM to 1:00 AM Saturday and Sunday 8:00 AM to 1:00 AM
Website	antidotehealth.com	24 hours a day 7 days a week
Mailing Address	[PO Box 39638 Solon, OH 44139]	24 hours a day 7 days a week

Throughout this document, You will find statements that encourage You to contact Us for further information. Whenever You have a question or concern regarding Your benefits, please call Member Services. It will be Our pleasure to assist You. In some areas, We have partnered with industry leading Specialists and may refer You to them for further assistance.

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

How to Use Your Evidence of Coverage

Read the entire EOC. Then keep it in a safe place for future reference.

Many of the sections of this EOC are related to other sections. You may not have all the information You need by reading just one section. Groups with special health care needs should read those sections that apply to them carefully.

You can find copies of Your EOC and any future Riders/Enhancements or Amendments at antidotehealth.com or request printed copies by contacting Member Services. Antidote will mail a written copy of Your EOC within seven (7) business days of Your request.

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.

When reviewing Your EOC, You should read the entire document and pay particular attention to Section V – Covered Health Care Services, and Section VI – Exclusions and Limitations.

You should also carefully read Section IV – How Your Plan Works.

Please call Us if You have questions about the Covered Services available to You. If there is a conflict between this EOC and any summaries provided to You by Us, the terms most favorable to You will apply. 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 II – Definitions. You should refer to Section II 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 Antidote. When We use the words "You" and "Your" in this EOC, We are referring to You as a Covered Person, or the Authorized Representative, as these terms are defined in Section II – Definitions.

Finding a Provider

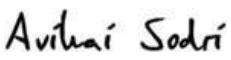
A listing of Network Providers is available online at antidotehealth.com. We have Plan Providers, Hospitals, and other medical practitioners who have agreed to provide You healthcare services. You can find Our Network Providers by visiting Our website and using the “Find a Doctor” function. There You will have the ability to narrow Your search by Provider specialty, zip code, gender, languages spoken and whether or not they are currently accepting new patients. Your search will produce a list of Providers based on Your search criteria and will give You other information such as name, address, phone number, office hours, qualifications, specialty, and board certifications.

At any time, You can request a printed copy of the Provider directory at no charge by calling Member Services at the toll-free number on Your ID Card. In order to obtain benefits, You must designate a Network Primary Care Physician for each Covered Person. We can help You pick a Primary Care Physician (PCP). Call the Provider’s office if You want to make an appointment. If You need help, call Member Services at the toll-free number on Your ID Card. We will help You make the appointment.

Identification (ID) Card

When You are enrolled, We will mail You an ID Card and a Welcome Letter after We receive Your completed enrollment materials, and We have received the initial Premium payment from Your employer. This card is proof that You are enrolled in an Antidote Plan. You need to keep this card with You at all times. Please show this card every time You go for any health care service under this contract, including to a Network Pharmacy.

Signed for Antidote Health by:



Avihai Sodri, CEO

SECTION II – DEFINITIONS

Active Course of Treatment: (A) An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; or (B) 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; or (C) The second or third trimester of pregnancy, through the postpartum period; or (D) An ongoing course of treatment for a health condition for which a treating Physician or Health Care Provider attests that discontinuing care by that Physician or Health Care Provider would worsen the condition or interfere with anticipated outcomes.

Acute: The onset of disease or injury, or a change in the Covered Person's condition that would require prompt medical attention.

Adverse Benefit Determination: A decision by Antidote:

- To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
  - A determination that the health care service does not meet Antidote's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigative treatments;
  - A determination of a Group Member's eligibility for benefits under the Plan;
  - A determination that a health care service is not a covered benefit;
  - The imposition of an Exclusion, including Exclusions for source of injury, Network, or any other limitation on benefits that would otherwise be covered.
- To rescind coverage on a health benefit Plan.

Allowed Amount or Maximum Allowable Amount: The maximum amount on which Our payment is based for Covered Services. See the COST-SHARING AND PAYMENT OBLIGATIONS section of this Group Policy for a description of how the Allowed Amount is calculated.

Ambulance: Any publicly or privately owned surface, water or air vehicle, including a helicopter, that contains a stretcher and necessary medical equipment and supplies, and that is especially designed and constructed or modified and equipped to be used, maintained or operated primarily to transport individuals who are sick, injured, wounded or who require medical monitoring or aid.

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

- A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an Adverse Benefit Determination;
- A person authorized by law to provide substituted consent for a covered individual;
- A family member or a treating Health Care Provider, but only when the Covered Person is unable to provide consent.

Balance Billing: When a Provider bills You for an amount greater than Your applicable Copayment, Coinsurance, and Deductible. A Network Provider may not Balance Bill You for Covered Services.

Benefit Period or Plan Year: If You are enrolled through a Group contract, Your benefit year begins on the Group Effective Date (always the first of a calendar month) and continues for 12 months from that date. (For example, if the Group Effective Date is April 1, Your benefit year runs from April 1 to March 31.) The benefit year then renews thereafter for 12-month periods. (If You were a new employee

who became a Group Member after the Group Effective Date, Your benefit year is the same as the benefit year for all Group Members in Your Group. That means that Your first benefit year will not be a full 12 months.)

Benefit Period Maximum: The maximum that We will pay for specific Covered Services during a Benefit Period.

Brand Name Drug: The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer's own registered trade name or trademark.
The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new Drug for a certain number of years.

Child, Children: The enrollee's Children, including any natural, adopted or stepchildren, unmarried disabled Children, newborn Children, or any other Children as described in the WHO GETS BENEFITS section of this Group Policy.

Coinsurance: A specific percentage of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which You must pay. Coinsurance normally applies after the Deductible that You are required to pay. See the Schedule of Benefits for any exceptions. Your Coinsurance does not apply to charges for services which are not covered and will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment: A specific dollar amount of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which You must pay. The Copayment does not apply to any Deductible that You are required to pay. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.

Cost-Sharing/Cost Share: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Covered Drugs: Injectable insulin, Legend Drugs, or such Drugs that Antidote designates as covered, so long as the following conditions are met:

- It is Medically Necessary and is ordered by an authorized Health Care Provider naming a Covered Person as the recipient;
- A prescription for the Drug must be issued by a prescriber who is legally authorized to prescribe Drugs for human use;
- The cost of the Drug must not be included in the charge for other services or supplies and for which a separate charge is customarily made;
- The Drug is not entirely consumed at the time and place where the prescription is written. Medically Necessary Drugs entirely consumed at the time and place where the prescription is written are covered under Your medical benefits rather than Your Pharmacy benefits;
- Which is dispensed by a Pharmacy and is received by the Covered Person while covered under an Antidote Plan, except when received from a Provider's office, or during confinement while a patient in a Hospital or other Acute Care or Facility (refer to Limitations and Exclusions). Medically Necessary Drugs received from a Provider's office or during confinement while a patient in a Hospital or other Acute Care or Facility are covered under Your medical benefits rather than Your Pharmacy benefits;
- Except as otherwise noted in this Plan, the Drug must be approved by the Food and Drug Administration (FDA) for treatment of the condition for which it is prescribed or recognized for treatment of the condition for which it is prescribed by:
    - the American Hospital Formulary Service Drug Information,
    - the United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional" or

- two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective for treatment of the condition unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

Any compounded Drugs are covered if they meet all the above requirements, subject to the provisions and Exclusions of this Plan.

Covered Person: The enrollee, including covered Dependents, who are properly enrolled by Antidote and due to such enrollment, are entitled to receive benefits provided under this Plan. Often, a Covered Person is referred to as "You."

Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Group Policy.

Custodial Service or Care: Care designed to assist You with activities of daily living and which can be provided by a layperson. Custodial Care is not specific treatment for an illness or injury and cannot be expected to substantially improve a medical condition. Such care includes, but is not limited to:

- Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
- Preparation and administration of special diets;
- Supervision of the administration of medication by a caregiver;
- Supervision of self-administration of medication; or
- Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care, or recreational care.

Deductible: The amount You owe before We begin to pay for Covered Services, listed in the Schedule of Benefits. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependent: The enrollee's Spouse or Children, who are covered under the Group Policy, as described in the WHO GETS BENEFITS section.

Diagnostic (Service/Testing): A test or procedure performed on a Covered Person, who is displaying specific symptoms, to detect or monitor a disease or condition. A Diagnostic Service also includes a Medically Necessary preventive care screening test that may be required for a Covered Person who is not displaying any symptoms. However, this must be ordered by a Provider.

Domiciliary Care: 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.

Durable Medical Equipment (DME): Equipment which:

- Can withstand repeated use;
- Generally is not useful to a person in the absence of illness or injury;
- Is appropriate for use in an individual's home or may be necessary for use at other locations or in the community to allow basic activities of daily living (ADLs); and
- Is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience.

Effective Date: The date that Your coverage begins under this Group Policy.

Emergency Medical Condition: A medical condition that manifests itself by such Acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health, including mental health, of the individual or, with respect to a pregnant woman, the health of the woman or her unborn Child, in serious jeopardy;
- Serious impairment to bodily function of the individual;
- Serious dysfunction of any bodily organ or part of the individual;
- Harm to the individual or others.

Emergency Services: Those health care services that must be available on a seven-days-per-week, twenty-four-hours-per-day basis to Stabilize an Emergency Medical Condition as soon as possible and are within the capabilities of the staff and facilities available at an Independent Freestanding Emergency Department or at a Hospital, including any ancillary services routinely available to the emergency department and any trauma and burn center of the Hospital. Including, where appropriate, provisions for treatment of Emergency Medical Conditions in out-of-area coverages.

Exclusions: Health care services that We do not pay for or cover.

Experimental/Investigative: 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 that does not meet established standards of medical practice. This definition does not apply to, and the Plan will not classify as Experimental or Investigative, any service or treatment otherwise required to be covered under applicable state or federal law. This includes, but is not limited to, routine patient care costs for a Covered Person enrolled in an approved clinical trial, medically accepted off-label uses of Prescription Drugs, mandated biomarker testing, or any other service explicitly outlined as a covered benefit under this Policy. For details on how the Plan determines Experimental or Investigative status, please refer to the EXCLUSIONS AND LIMITATIONS section.

Final Adverse Benefit Determination: An Adverse Benefit Determination that is upheld at the completion of Antidote's internal appeals process.

Formulary: The list that identifies those Prescription Drugs for which coverage may be available under the Prescription Drug or medical benefit under this Plan. You may determine if a Prescription Drug is on the Formulary, or which tier a particular Prescription Drug has been assigned to, by visiting antidotehealth.com or by calling Antidote at the toll-free number on Your ID Card.

Generic Drugs: Prescription Drugs that have been determined by the Food and Drug Administration (FDA) to be equivalent to Brand Name Drugs but are not made or sold under a registered trade name or trademark. Generic Drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the Brand Name Drug.

Group: An employer or other legal entity, as defined by the laws of the state of Arizona and the Employee Retirement Income Security Act of 1974 (ERISA), unless the Group is not a private plan sponsor subject to ERISA, that is eligible to offer a Group Policy to arrange for the provision of Group coverage to Group Members. An employer Group subject to ERISA is the ERISA plan sponsor. Antidote is not the plan sponsor. If You are a Group Member through a Group, the Group is Your agent, not Antidote's agent.

Group Member: A category of enrollee (such as enrollee only, enrollee and Spouse, enrollee and children or enrollee and family) who receives coverage under the Plan through a Group Policy.

Group Policy: The agreement between a Group and Antidote under which:

- Antidote agrees to arrange for the Group to obtain coverage under the Plan; and
- The Group agrees to pay the Premium to Antidote for coverage under the Plan for active and inactive employees. Group determines eligibility of coverage for Group Members.

The Group Policy includes this EOC and the applicable Schedule of Benefits and Coverage, including any riders and amendments that describe the Covered Services, required Deductible, Copayments, Coinsurance and the terms, conditions, limitations and Exclusions related to coverage. This is the document which describes the agreements between the Group and Us. The Group Policy provides a summary of the terms of Your benefits. Group Policy may also be referred to as "Plan."

Habilitative Services: Health care services or devices that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy, and speech therapy.

Hearing Aid: Any wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing, including all attachments, accessories, and parts thereof, except batteries and cords, that is dispensed by a licensed audiologist, a licensed hearing aid dealer or fitter, or an otolaryngologist.

Hospitalization: Care in a Hospital that requires admission as an Inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

Identification Card / ID Card: A card issued by Us to You, showing Your name, membership number, and general Plan information.

In-Network/Network: Services provided by a Network Provider.

Independent Freestanding Emergency Department: A health care Facility that is geographically separate, distinct, and licensed separately from a Hospital under applicable state law and provides any Emergency Services.

Independent Review Organization: An entity that is accredited to conduct independent external reviews of Adverse Benefit Determinations pursuant to section A.R.S. 20-2537.

Inpatient: Care as a registered bed patient in a Hospital or other Facility where a room and board charge is made. This does not apply to a Covered Person who is placed under observation for fewer than twenty-four (24) hours.

Intensive Outpatient Program (IOP): A licensed and approved evening treatment program. Such programs offer treatment of alcohol or other Drug dependence for nine (9) or more hours per week to individuals or groups of individuals who are not admitted as Inpatients. This term may also be referred to as "Intensive Outpatient Treatment."

Medically Necessary / Medical Necessity: See the HOW YOUR PLAN WORKS section of this Group Policy for the definition.

Medicare: A federal health insurance program for people age sixty-five (65) or older, people under age sixty-five (65) with certain disabilities, and people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Mental Health Condition: A behavioral, emotional, or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life.

Out-of-Pocket Limit: The most You pay during a Benefit Period in Cost-Sharing (as listed on Your

Schedule of Benefits) before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium or the cost of health care services We do not cover.

Outpatient: A Covered Person who receives services or supplies while not an Inpatient.

Partial Hospitalization or Partial Day Services: A licensed and approved day treatment program that includes the major Diagnostic, medical, psychiatric, and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other Drug dependence who require coordinated, intensive, comprehensive, and multidisciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as Inpatients.

Pharmacy and Therapeutics (P&T) Committee: A committee consisting of Health Care Providers, including nurses, pharmacists, and Physicians. The purpose of this committee is to assist in determining clinical appropriateness of Drugs; determining the assignments of Drugs; determining whether a Drug will be included in any of the Formularies; and advising on programs to help improve care. Such programs may include, but are not limited to, Drug utilization programs, Prior Authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physician-Administered Drug: An Outpatient Drug other than a vaccine that is typically administered by a Health Care Provider in a Physician's office or other Outpatient clinical setting. For example, Drugs that are infused or injected are typically Physician-Administered Drugs. Physician-Administered Drugs require Prior Authorization and consultation with a Case Manager to assess the appropriateness of the site of care and alternative treatment options.

Physician Services: Health care services a licensed medical Physician provides or coordinates.

Placement for Adoption: The assumption and retention by a person of a legal obligation for total or partial support of a Child in anticipation of the adoption of the Child. The Child's placement with a person terminates upon the termination of that legal obligation.

Plan: this Antidote plan.

Premium: The amount that must be paid for Your health insurance coverage.

Prescription Legend Drug, Prescription Drug, or Drug: A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or refill and is on the Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Covered Prescription Drugs

- A Prescription Legend Drug for which a written prescription is required. A Legend Drug is one which has on its label "caution: federal law prohibits dispensing without a prescription";
- Insulin; pre-filled insulin cartridges for the blind; oral blood sugar control agents;
- Needles, syringes, glucose monitors, and machines, glucose test strips, visual reading ketone strips; urine test strips, lancets and alcohol swaps are all covered when dispensed by the mail order and retail pharmacy program;
- A compound medication of which at least one ingredient is a Prescription Legend Drug;
- Tretinoin for individuals through age 24;
- Any other Drug which, under the applicable state law, may be dispensed only upon the written prescription of a Provider;
- Oral contraceptives or contraceptive devices, regardless of intended use, except that implantable contraceptive devices, such as Norplant, are not considered Covered Prescription Drugs;
- Prenatal vitamins, upon written prescription;
- Growth hormones (with Prior Authorization); or

- Injectable Drugs or medicines for which a prescription is required, except injectable infertility Drugs.

Prescription Order: A legal request, written by a Provider, for a Prescription Drug or medication and any subsequent refills.

Prior Authorization: The determination by Antidote, or a Utilization Review agent, that a health care service has been reviewed and based on the information provided, satisfies this Plan's requirements for Medical Necessity and appropriateness of a proposed treatment, including level of care and treatment setting, and payment under this Plan will be made for that health care service. Your Provider is required to request Prior Authorization from Us.

A Prior Authorization request, once granted or deemed granted, is binding on this Plan, and may not be rescinded or modified by Us or a Utilization Review agent, after We render the authorized health care services in good faith and pursuant to the Prior Authorization, unless there is evidence of fraud or misrepresentation by the Provider.

Provider: A Physician, Health Care Provider or Facility licensed, registered, certified, or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, DME, medical supplies, or any other equipment or supplies that are covered under this Group Policy that is licensed, registered, certified or accredited as required by state law. Providers include, but are not limited to, the following persons and facilities listed below. If You have a question about a Provider not shown below, please call the number on the back of Your ID Card.

Unless otherwise expressly required by applicable law or specifically stated in this Policy, references to a "Physician" are intended to include any appropriately licensed Provider acting within the scope of the Provider's license or other legal authority under Arizona law to perform the applicable service or function. Nothing in this Policy is intended to restrict the delivery of Covered Services by a licensed Provider acting within the Provider's lawful scope of practice.

- **Alcoholism Treatment Facility** – A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.
- **Alternative Care Facility** – A non-Hospital health care facility, or an attached facility designated as free standing by a Hospital that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery; and
    - Therapy Services or rehabilitation.
- **Ambulatory Surgical Center** – A facility, with an organized staff of Physicians, that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.
- **Clinical Nurse Specialists** – whose nursing specialty is Mental Health.
- **Day Hospital** – A facility that provides day Rehabilitation Services on an Outpatient basis. Day Rehabilitation Services are for those patients who do not require Inpatient care but still require Rehabilitation Services four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day Rehabilitation Services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuropsychological services. A minimum of two (2)

Therapy Services must be provided for this program to be a Covered Service. Services provided in a Day Hospital are subject to a combined visit limit with other Outpatient Therapy Services.

- **Dialysis Facility** – A facility which mainly provides dialysis treatment, maintenance, or training to patients as an Outpatient or at Your home. It is not a Hospital.
- **Drug Abuse Treatment Facility** – A facility which provides detoxification and/or rehabilitation treatment for Drug abuse.
- **Facility** – A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; Hospice; Home Health Care Agency; a comprehensive care center for eating disorders pursuant to state law.
- **Health Care Provider** – A licensed Hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under any applicable law, including a Physician, podiatrist, optometrist, Psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide Behavioral Health Care Services.
- **Home Health Care Agency** – A facility, licensed in the state in which it is located, which:
    - Provides skilled nursing and other services on a visiting basis in the Covered Person's home; and
    - Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Provider.
- **Home Infusion Facility** – A facility which provides a combination of:
    - Skilled nursing services;
    - Prescription Drugs; and
    - Medical supplies and appliances in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.
- **Hospice or Hospice Care**– A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health 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. Care is available twenty-four (24) hours a day, seven (7) days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.
- **Hospital** – A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:
    - Provides room and board and nursing care for its patients;
    - Has a staff of at least two or more Physicians who have clinical privileges to admit inpatients and every inpatient is under the care of a medical practitioner who coordinates the inpatient's care;
    - Provides twenty-four (24) hour nursing service by or under the supervision of a registered professional nurse (R.N.);
    - Has organized departments of medicine and major surgery;
    - Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
    - Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.
    - The term Hospital does not include a Provider, or that part of a Provider, used mainly for:
        - Nursing care
        - Rest care
        - Convalescent care
        - Care of the aged

        - Custodial Care
        - Educational care
        - Treatment of alcohol abuse
        - Treatment of Drug abuse
    - Hospital does not mean health resorts, spas or infirmaries at schools or camps.
    - Hospital also includes an Independent Freestanding Emergency Department, when providing Emergency Services to You.
- **Network Provider** – A Provider who has a contract with Us to provide services to You. A list of Network Providers and their locations is available on Our website at antidotehealth.com or upon Your request to Us. The list will be revised from time to time by Us.
    - Antidote's In-Network lab Providers consist of lab Providers that have demonstrated high standards for access, quality, cost, data, and service based on proprietary criteria. We will only pay for lab work conducted by an In-Network lab Provider, unless conducted in the event of an emergency.
- **Out-of-Network Provider** – A Provider who doesn't have a contract with Us to provide services to You. The services of Out-of-Network Providers are covered only for Emergency Services or when authorized by Us.
- **Outpatient Psychiatric Facility** – A facility which mainly provides Diagnostic and therapeutic services for the treatment of Mental Health Conditions or Substance Use on an Outpatient basis.
- **Pharmacy** – An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a medical practitioner's order.
- **Physician** – Means a doctor of medicine; doctor of osteopathy; doctor of dental surgery or of dental medicine; doctor of podiatric medicine; or doctor of optometry who is legally authorized to practice medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, or optometry by the State in which they perform such function and who is acting within the scope of their license when they perform such functions.
- **Primary Care Physician/Primary Care Provider (PCP)** – A Network Provider who typically is an internal medicine, family practice, general practice, obstetrics/gynecology, geriatrics, or pediatric Physician and who directly provides or coordinates a range of health care services for You.
- **Professional Clinical Counselors** – A licensed clinical professional counselor (LPCC) providing psychotherapy, talk therapy, treatment plans, and other counseling services.
- **Professional Counselors** – A licensed professional counselor, including an LPC, Licensed Clinical Social Worker (LCSW), and Licensed Mental Health Counselor (LMHC).
- **Psychiatric Hospital** – A facility that is primarily engaged in providing Diagnostic and therapeutic services for the Inpatient treatment of Mental Health Conditions or Substance Use. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.
- **Psychiatrist** – A licensed clinical psychiatrist. In states without licensure laws, a psychiatrist must be certified by the appropriate professional body.
- **Psychologist** – A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.
- **Rehabilitation Hospital** – A facility that is primarily engaged in providing Rehabilitation Services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.
- **Retail Health Clinic** – A facility that provides limited basic medical care services to Covered Persons on a "walk-in" basis. These clinics normally operate in major Pharmacies or retail stores. Medical services are typically provided by Physician assistants and nurse practitioners.

- **Skilled Nursing Facility** – A Provider constituted, licensed, and operated as set forth in applicable state law, which:
    - mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
    - provides care supervised by a Physician;
    - provides twenty-four (24) hour per day nursing care supervised by a full-time registered nurse;
    - is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or Drug dependency; and
    - is not a rest, educational, or custodial Provider or similar place.
- **Social Worker** – A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.
- **Specialist** – A Physician or Health Care Provider who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. You will need a Referral in order to receive care from a Specialist.
- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**
- **Urgent Care Center** – A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Travel Expenditures: Transportation, room and board costs incurred while obtaining Covered Services Prior Authorized by Us outside the Service Area in cases where it has been determined by Us that the Prior Authorized Covered Services are not available in the Service Area.

Referral: A recommendation given to one Network Provider from another Network Provider (usually from a PCP to a Network Specialist) in order to arrange for additional care for a Covered Person. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an Inpatient and/or Outpatient setting.

Residential Treatment: Treatment of Mental Health Conditions and/or Substance Use provided in a Hospital or treatment facility licensed to provide a continuous, structured program of treatment and rehabilitation, including twenty-four (24) hour-a-day nursing care. Individualized and intensive treatment includes observation and behavioral health assessment by a behavioral health professional at least weekly and rehabilitation, therapy, education, and recreational or social activities. Residential Treatment Centers are only covered when qualified as a mental health facility or Substance Use facility providing continuous, structured, twenty-four (24) hour-a-day program of mental health, Drug or alcohol treatment and rehabilitation including twenty-four (24) hour-a-day nursing care.

Schedule of Benefits: A document, incorporated by reference in this Group Policy that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Prior Authorization requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of Arizona, in which We provide coverage.

Spouse: The person to whom the enrollee is legally married, including a same sex Spouse. Spouse also includes a domestic partner.

Stabilize: The provision of such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of an individual's medical condition is likely to result

from or occur during a transfer to a Network facility or discharge of the individual from a facility, if the medical condition could result in any of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn Child, in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part. In the case of a woman having contractions, Stabilize means such medical treatment as may be necessary to deliver, including the placenta.

Non-emergency medical transportation, including interfaculty transports must be Prior Authorized.

Substance Use: Alcohol, Drug or chemical abuse, overuse, or dependency.

Telemedicine or Telehealth: The delivery of health care services through synchronous or asynchronous information and communication technology by a Health Care Provider, within the Health Care Provider's scope of practice, who is located at a site other than the site where the recipient is located.

Therapeutic Abortion: an abortion performed to save the life or health of a mother, or as a result of incest or rape.

Therapy Services: Services and supplies that are used to help a person recover from an illness or injury. Covered Therapy Services are limited to services listed as Covered Services in this Group Policy.

Urgent Care: 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 injured or ill person, and may include such health care services provided out of Antidote's approved Service Area pursuant to indemnity payments or service agreements.

Utilization Review ("UR"): a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Utilization Review shall not include elective requests for clarification of coverage.

We, Us, Our, and Ours: Antidote.

You and Your: The Covered Person and/or any Dependents covered by this Group Policy.

SECTION III – MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You have the right:

- To receive information about the organization, its services, its practitioners, Providers, and Your rights and responsibilities.
- To be treated with respect and recognition of Your dignity and Your right to privacy.
- To participate with practitioners in making decisions about Your health care.
- To a candid discussion of appropriate or Medically Necessary treatment options for Your conditions, regardless of cost or benefit coverage.
- To voice complaints or appeals about the organization or the care it provides.
- To make recommendations regarding the organization's Member Rights and Responsibilities policy.
- To have access to a current list of Network Providers. Additionally, a Member may access information on Network Providers' education, training, and practice.
- To receive information in a different format in compliance with the Americans with Disabilities Act if You have a disability.
- To select a Primary Care Provider within the Network. You have the right to change Your Primary Care Provider or request information on Network Providers close to Your home or work.
- To know the name and job title of people providing care to You. You also have the right to know which Provider is Your Primary Care Provider.
- To a second opinion by a Network Provider, at no cost to You, if You believe that the Network Provider is not authorizing the requested care, or if You want more information about Your treatment.
- To privacy of Your personal health information, consistent with state and federal laws, and Plan policies.
- To be kept informed of covered and non-covered services, program changes, how to access services, Primary Care Provider assignment, Providers, advance directive information, Referrals and Prior Authorizations, benefit denials, Member rights and responsibilities, and other Plan rules and guidelines. The Plan will notify You at least 60 days before the Effective Date of the modifications. Such notices shall include the following:
    - To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual orientation, national origin, or religion. Sex discrimination includes, but is not limited to, discrimination based on pregnancy, gender identity and sex stereotyping.
    - To have access to an interpreter when You do not speak or understand the language of the area.
- To execute an advanced directive for health care decisions. An advance directive will assist the Primary Care Provider and other Providers to understand Your wishes about the Your health care. The advance directive will not take away Your right to make Your own decisions. Examples of advanced directives include:
    - Living Will
    - Health Care Power of Attorney
    - "Do Not Resuscitate" Orders
    - Members also have the right to refuse to make advance directives. Members may not be discriminated against for not having an advance directive.

As a Member, You have the responsibility:

- To supply information (to the extent possible) that the organization and its practitioners and Providers need in order to provide care.
- To follow plans and instructions for care that You have agreed to with Your practitioners.
- To understand Your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- To treat all health care professionals and staff with courtesy and respect.
- To show Your ID Card and keep scheduled appointments with Your Provider and call the Provider's office during office hours whenever possible if You have a delay or cancellation.
- To know the name of Your assigned Primary Care Provider. You should establish a relationship with Your Primary Care Provider. You may change Your Primary Care Provider verbally or in writing by contacting the Plan's Member Services Department.
- To follow all health benefit Plan guidelines, provisions, policies, and procedures.
- To use an emergency room only when You think You have a medical emergency. For all other care, You should seek care at an Urgent Care Center, Antidote virtual Provider or call Your Primary Care Provider.
- To give all information about any other medical coverage You have at the time of enrollment. If, at any time, You gain other medical coverage besides Antidote coverage, You must provide this information to Antidote.
- To pay Your monthly Premium, all Deductible amounts, Copayment amounts, or other Cost-Sharing amounts at the time of service.

SECTION IV – HOW YOUR PLAN WORKS

Your Coverage Under this Plan

Your employer has purchased a health insurance Plan from Us. We will provide the benefits described in this Plan to You and Your covered Dependents. You should keep this Plan with Your other important papers so that it is available for Your future reference.

In the event of Antidote elects to not renew Your Group Policy or terminates coverage under this Plan, We will provide Your Employer with 180 days' written notice prior to the renewal date of the Plan. You may qualify for a Special Enrollment Period. Please visit Get Marketplace health coverage outside Open Enrollment only with a Special Enrollment Period | HealthCare.gov

Choosing a Primary Care Physician or a Primary Care Provider (PCP)

You must select a Primary Care Physician, who is in the Service Area, to obtain benefits. A Primary Care Physician may also be referred to as a PCP. A Primary Care Physician will be able to coordinate all Covered Services and submit Referrals for services to Network Providers. If You are the custodial parent of a Dependent Child, You must select a Primary Care Physician who is in the Service Area, for that Child. For Children, You may designate a pediatrician as the Primary Care Physician. If You do not select a Primary Care Physician for Yourself or Your Dependent Child, one will be assigned.

For obstetrical or gynecological care, You do not need a Referral from a Primary Care Physician and may seek care directly from any Network Provider who specializes in obstetrics or gynecology.

Specialists

A wide range of Specialists are included in the Antidote Network. You will need a Referral in order to receive care from a Specialist. When You need a Specialist's care, In-Network benefits will be available, but only if You use a Network Provider. There may be occasions however, when You need the services of an Out-of-Network Provider. This could occur if You have a complex medical problem that cannot be taken care of by a Network Provider. If the services You require are not available from Network Providers, In-Network benefits will be provided when You use Out-of-Network Providers. Contact Us at the toll-free number on Your ID Card to request the necessary Prior Authorization for Out-of-Network services in this situation.

Standing Referrals

You may also request a standing Referral from Your Primary Care Physician. Your Primary Care Physician will confer with a Specialist and determine whether You need continuing care from a Specialist. This Referral will remain in effect even if Your Primary Care Physician leaves the health care services Network. The Referral will be made pursuant to a treatment plan approved by Antidote in consultation with You, Your Primary Care Physician, and the Specialist. The treatment plan may limit the number of visits to the Specialist, limit the period of time for which the visits are authorized, or require the Specialist to provide Your Primary Care Physician with regular reports on the health care provided to You. Within three (3) business days of Our receipt of Your request, We will make a determination provided that We have all information necessary to do so.

If You have a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling, You may receive a Referral to a Specialist who has expertise in treating the condition. The Specialist will direct care in the same manner as Your Primary Care Physician. In addition, such a Referral will be available if Your Primary Care Physician determines in consultation with the Specialist that You need the Specialist's expertise. The Referral and treatment by the Specialist will be pursuant to a treatment plan approved by Us in consultation with

You, Your Primary Care Physician, and the Specialist. If the Specialist leaves the Network or You cease to be covered, the Standing Referral will expire.

Emergency Services and Care

If You immediately need Medically Necessary Emergency Services, We will provide coverage for those services if they are provided by a Network or an Out-of-Network Provider. We will provide benefits for this care, if received from an Out-of-Network Provider to the same extent as would have been provided if care and treatment were provided by a Network Provider. We will provide benefits for this care until Your medical condition permits travel or transport to a Network Provider. If You receive care and treatment for an Emergency Medical Condition from an Out-of-Network Provider, after the initial medical screening examination and any immediately necessary stabilizing treatment, You should notify Us by calling the twenty-four (24) hour telephone number located on Your ID Card.

Emergency Services are available at any Out-of-Network Hospital, within or outside of the Service Area.

We do not provide coverage for out-of-area services for anything other than Emergency Services as outlined above and Urgent Care services subject to the conditions specified in the Urgent Care section of this Plan. Be sure to call Us and report Your emergency within one business day. You do not need prior approval for Emergency Services.

After Hours Care

If You need care after normal business hours, Your Provider may have several options for You. You should call Your Physician's office for instructions if You need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If You have an emergency, call 911 or go to the nearest emergency room.

Network Providers

This Plan only covers Network benefits. To receive Network benefits, You must receive care exclusively from Network Providers in Our Network. Services must be performed or supplies furnished by a Network Provider for benefits to be payable. There are no benefits provided when using an Out-of-Network Provider and You will be responsible for paying the cost of all care that is provided by Out-of-Network Providers unless We have Prior Authorized that care or the Out-of-Network Provider is administering Emergency Services (as described in the COVERED HEALTH CARE SERVICES section of this Plan).

Network Providers must seek compensation for Covered Services solely from Antidote, except for Copayments, Coinsurance and/or Deductibles. To find out if a Provider is a Network Provider:

- Check Your Provider directory, available at Your request;
- Call the toll-free number on Your ID Card; or
- Visit Our website at antidotehealth.com.

To reduce Your Out-of-Pocket costs, be sure to confirm that the Provider You wish to see is a Network Provider. For example, if You are treated for a non-Emergency Service in a Hospital, it is especially important to check ALL Your Providers' Network statuses. While Your treating Provider may be participating in the Antidote Network, other Providers involved, such as anesthesiologists, pathologists, or radiologists, may not be part of Your Network of Providers.

We may pay for certain Medically Necessary Out-of-Network services if Antidote determines, in Our sole discretion, that You received such Medically Necessary Out-of-Network services on an involuntary basis as a result of receiving Covered Services from a Network Provider, did not elect to receive

Services from an Out-of-Network Provider, and a Network Provider was not available to render such Medically Necessary Services to You. Notwithstanding any provision of this Policy to the contrary, this Plan provides protections against surprise medical bills in accordance with the federal No Surprises Act and Arizona law (A.R.S. § 20-3113 et seq.). If You receive covered Emergency Services, or certain non-emergency services from an Out-of-Network provider at an In-Network facility (such as anesthesiology or radiology), Your services will be paid at the In-Network level. Your Cost-Sharing (i.e., Deductible, Copayment, and Coinsurance) will be based on the In-Network benefit, and that amount will count toward Your In-Network Deductible and Out-of-Pocket Limit. You will not be Balance Billed by these providers for any amount beyond your In-Network Cost-Sharing. Any applicable Copayment, Coinsurance and Deductible would apply to Your maximum Out-of-Pocket.

Your Out-of-Pocket cost will not exceed the rate negotiated between Us and the Provider.

Out-of-Network Providers

If You elect to see an Out-of-Network Provider when the services could have been provided by a Network Provider, no benefits will be available.

Arizona Ins. Code § 20-3113 and the Federal No Surprises Act establish patient protections, including protections against Out-of-Network Providers' surprise bills ("Balance Billing") for Emergency Services and other specified items or services. We will comply with these new state and federal requirements including how We process claims from certain Out-of-Network Providers.

When You visit an Out-of-Network Provider for Prior Authorized services not available from Network Providers, or if You cannot reasonably reach a Network Provider for Emergency Services, We will:

- pay the claim at the In-Network benefit Cost-Sharing level; and
- when issuing payment, provide You with an explanation of benefits.

In the event You receive Prior Authorized services from an Out-of-Network Provider, You are only responsible for In-Network level of Cost-Sharing. As part of the Utilization Review process, Antidote or its Utilization Review agent will make best efforts to enter into a single case agreement (SCA) with the Out-of-Network Provider. Regardless of whether Antidote or its designee is successful securing an SCA, the In-Network level of benefits will apply.

Because the services are Prior Authorized, there should be no costs incurred by You beyond the In-Network level. The SCA will expressly state the prohibition against Balance Billing You for any amounts above what has been contractually agreed to between the Out-of-Network Provider and the Plan.

Utilization Review Decisions, Timeframes and Procedures

For initial determinations, We (or the Utilization Review vendor delegated to act on Our behalf) will make Our determinations within the following timeframes:

- For pre-service urgent requests: within one (1) business day.
- For pre-service non-urgent requests: within fifteen (15) calendar days.
- For concurrent urgent requests (submitted in a timely manner – for an extension of care approved previously, where the request is received more than twenty-four (24) hours before the expiration of the urgent authorization): within one (1) calendar day.
- For post-service requests: within thirty (30) days.

For approvals, We will provide written notification of Our decision within two (2) business days of Our decision.

For denials (Adverse Determinations), We will provide verbal and written notification within one (1) business day of Our determination. In any case where the National Committee for Quality Assurance

(hereby referred to as “NCQA”) or federal authorization time frames conflict with Arizona standards, We will adhere to the stricter of all relevant time frames.

Designation of an Authorized Representative

You have the right to designate an Authorized Representative. If You wish to do so, You must complete and sign an Authorized Representative form. This form can be obtained by calling the Member Services Team at the telephone number indicated on the back of Your Identification Card.

Prior Authorization for Inpatient and Outpatient Services

Prior Authorization is required for all non-emergency Inpatient admissions, and certain other admissions, to be eligible for benefits. The list of services subject to Prior Authorization can be accessed online at antidotehealth.com.

Prior Authorization is required for payment of benefits. Coverage is always subject to other requirements of this Plan limitations and Exclusions, payment of Premium and eligibility at the time care and services are provided.

Emergency Services and emergency inpatient admissions do not require Prior Authorization for the initial medical screening examination and immediately necessary stabilizing treatment of an Emergency Medical Condition. Following stabilization, We may conduct a review to determine the Medical Necessity of continued services and may require Prior Authorization for post-stabilization care. We may also direct Your care, including arranging transfer to a Network Provider, provided the treating Provider determines You are stable for transfer and transfer requirements are met. Such post-stabilization review and care direction do not affect coverage of the initial Emergency Services and stabilizing treatment rendered prior to stabilization. To obtain Prior Authorization or verify requirements for Inpatient or Outpatient Services, including which services require Prior Authorization, You or Your Provider can call Antidote at the toll-free number on Your ID Card or online at antidotehealth.com.

If a Network Provider fails to obtain a Prior Authorization, the claim will be denied for lack of Prior Authorization. The Network Provider’s Antidote Participation Agreement prohibits the Network Provider from billing the member for the services denied for no Prior Authorization

In order to minimize the potential for care delays, We recommend that Prior Authorization requests be received within the following timeframes when feasible:

- At least five (5) days prior to an elective admission as an Inpatient in a Hospital, extended care or rehabilitation facility, or Hospice facility.
- At least thirty (30) days prior to the initial evaluation for organ transplant services.
- At least thirty (30) days prior to receiving clinical trial services.
- At least five (5) days prior to a scheduled Inpatient behavioral health or Substance Use treatment admission.
- At least five (5) days prior to the start of home health care services.

Retrospective Review

Retrospective review is an initial review of services after services have been provided. A retrospective review involves the evaluation of clinical records to determine the appropriateness and necessity of rendered care where notification was not received prior to services being rendered. All requests for services are reviewed utilizing appropriate decision protocols, which are based on reasonable medical evidence.

We will conduct a retrospective review and consider coverage for a service when a Prior Authorization was not obtained under the following conditions only:

Circumstance	Detailed Explanation
Emergency Medical Services	After You are Stabilized, the Provider should notify Us (or Our delegated Utilization Review agent) as soon as reasonably possible, and preferably within 24 hours to coordinate ongoing post stabilization care and transfer to a Network Provider if the treating Provider determines that transfer is clinically appropriate, and the receiving provider accepts the transfer. Notification is not a condition of coverage or payment for Emergency Services or emergency stabilization services.
Circumstance	Detailed Explanation
Urgent Care for an Unforeseen Condition	When a member requires Urgent Care for an unforeseen illness or injury that is not life-threatening but requires prompt medical attention. This applies when You are outside the Plan's Service Area and cannot access a Network Provider.
Inability to Verify Member Eligibility – Extenuating Circumstances	If the Provider is unable to determine Your insurance status or Plan requirements at the time of service (e.g., You were unconscious at presentation, You did not have Your Antidote ID card or otherwise indicated other coverage, services authorized by another payer that subsequently determined You were not eligible at the time of service), the Provider must demonstrate through submitted documentation they made a good-faith effort to identify coverage. Once eligibility is established, a retrospective review can be requested. Additional extenuating circumstances include: • The service is directly related to another service for which Prior Authorization was obtained and that has already been performed. • The new service was not known to be needed at the time the original Prior Authorized service was performed. • The need for the new service was revealed at the time the original Prior Authorized service was performed.

- For all scheduled, non-emergent services, it is the Provider's obligation to know and follow Antidote's Prior Authorization requirements. Forgetting to obtain an authorization or being unaware of the requirement is generally not a valid reason for requesting a retrospective review.
- When a retrospective review is permissible, the Provider must submit the notification within 30 calendar days of the earlier of the date of service or discharge.
- Antidote will evaluate the clinical documentation submitted by Your Provider to determine if the services rendered met the criteria for Medical Necessity.

It is important for You to remember that retrospective review in Arizona is primarily reserved for situations where obtaining a Prior Authorization was impossible or not required, such as in a true

emergency. For routine, scheduled services requiring Prior Authorization, the regulations are clear: providers must obtain authorization before rendering a service to ensure payment.

Adverse Determination

A written notification of an Adverse Determination will include the principal reason or reasons for the determination, the instructions for initiating an appeal of the determination, and the instructions for requesting a written statement of the clinical rationale, including a reference to specific criteria or guideline used in making the decision. Upon request, Antidote will provide a copy of the criteria or guideline used in Our decision. You may also request an Appeals Process Information Packet from Us by contacting Our Member Services by calling the toll-free number on Your ID Card. If You receive an Adverse Determination, You have the right to Appeal. Please refer to Section XIII – Appeals and Complaint Procedures.

In cases where the Provider or You will not release necessary information, Antidote may deny certification of an admission, procedure, or service.

If Antidote or its Utilization Review agent authorizes the provision of health care services, Antidote will not subsequently retract the authorization after the health care services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless such authorization is based on a material misrepresentation or omission about Your health condition or the cause of the health condition, or Your coverage under the Plan terminates before the health care services are provided.

Case Management

Case management helps coordinate services for Covered Persons with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Covered Persons who agree to take part in the case management program to help meet their health-related needs.

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and teamwork with You and/or Your Authorized Representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or Injury, We may provide benefits for alternate care through Our case management program that is not a Covered Service. We may also extend Covered Services beyond the Allowed Amounts of this Plan. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us. Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Covered Person.

Examples of the case management programs offered by this Plan are:

- Hypertension;
- Diabetes; and
- Mental Health.

These programs are designed to support Your engagement in a collaborative process to manage chronic medical and Mental Health Conditions more effectively.

We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate

care. In such case, We will notify You or Your Authorized Representative in writing.

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by Antidote. Charges for services and supplies which Antidote determines are not Medically Necessary may not be used to satisfy Deductibles or to apply to the maximum Out-of-Pocket amount.

We base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer-review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of Health Care Providers in the generally recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the diagnosis, direct care and treatment, appropriate management, or ongoing monitoring of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not Experimental/Investigative nor subject to an Exclusion under this Group Policy;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or Diagnostic results; and
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, We will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an Outpatient basis or an infusion or injection of a specialty Drug provided in the Outpatient department of a Hospital if the Drug could be provided in a Physician's office or the home setting.

Medically Necessary services provided to You by a family member are covered in the same manner as they would be covered if You received such Medically Necessary services from a Provider not related to You. Except for Emergency Services, coverage is limited to Medically Necessary services performed by In-Network Providers.

See the APPEALS AND COMPLAINT PROCEDURES section of this Group Policy for Your right to an Appeal and independent review of Our determination that a service is not Medically Necessary.

Identification Card

The Identification Card should be shared with Providers to allow them to verify Your eligibility and to identify covered benefits under Your Antidote Plan. The ID Card offers a convenient way of providing

important information specific to Your coverage including, but not limited to, the following:

- Your Member ID.
- Important telephone numbers.

Always remember to carry Your Identification Card with You and present it to Providers or Participating Pharmacies when receiving health care services or supplies. Please remember that any time a change in Your family takes place, issuance of a new ID Card may be necessary (refer to the WHO GETS BENEFITS section for instructions when changes are made). Upon receipt of the change in information, Antidote will provide a new ID Card. If You lose Your card and need to request a replacement, please call Member Services at the toll-free number on Your ID Card.

Telemedicine

Your coverage will include Telemedicine visit services provided by designated Network Providers. Benefits for these services are provided to the same extent as an in-person service under any applicable benefit category in this section unless otherwise specified in the Schedule of Benefits.

See Your Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit Limitation information.

Continuity of Care

In cases where a Network Provider is terminated, You may continue to receive coverage for services at the level of reimbursement applicable to similar services by Providers within the Network, as though termination had not occurred, until the earlier of 90 days or the date on which You are no longer a continuing care patient with respect to the Provider, for the following circumstances:

- You are or were determined to be terminally ill and are receiving treatment for such illness from the Provider.
- You are pregnant and are undergoing a course of treatment for the pregnancy from the Provider. This includes delivery and any care up to six (6) weeks after the delivery that is related to the delivery.
- You are undergoing an Active Course of Treatment for a serious and complex condition from the Provider.
- You are undergoing a course of institutional or Inpatient care from the Provider.
- You are scheduled to undergo nonelective surgery from the Provider, including receipt of postoperative care in connection with the surgery.

New enrollees may continue to receive coverage for benefits or services from a Provider who is not a Network Provider, upon written request by the enrollee to continue an Active Course of Treatment with the Provider, under the following circumstances:

- You are or were determined to be terminally ill and are receiving treatment for such illness from the Provider.
- You are pregnant and are undergoing a course of treatment for the pregnancy from the Provider. This includes delivery and any care up to six (6) weeks after the delivery that is related to the delivery.
- You are undergoing an Active Course of Treatment for a serious and complex condition from the Provider.
- You are undergoing a course of institutional or Inpatient care from the Provider.
- You are scheduled to undergo nonelective surgery from the Provider, including receipt of postoperative care in connection with the surgery.

Such coverage will be at the level of reimbursement applicable to similar services by Providers within

the Network, covered as such until the earlier of 90 days or the date on which You are no longer a continuing care patient with respect to the Provider.

A serious and complex condition is (i) in the case of an Acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (ii) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.

In both cases, the Provider must also continue to accept as payment in full reimbursement from Antidote at the rates applicable before the beginning of the transitional period, comply with Our Utilization Review requirements, and provide to Us any necessary medical information related to the care. The Provider must also comply with Our policies and procedures, including those related to obtaining Prior Authorization, claims handling and any treatment plans subject to approval by Us.

Continuity of Care benefits are subject to all other applicable provisions and terms of Your Plan. To request a continuity of care, please call Us at the toll-free number on Your ID Card.

Authorization to an Out-of-Network Provider

If We determine that We do not have a Network Provider that has the appropriate training and experience to treat Your condition, We will approve an authorization to an appropriate Out-of-Network Provider. Your Network Provider or You must request prior approval of the authorization to a specific Out-of-Network Provider. Approvals of authorizations to Out-of-Network Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Out-of-Network Provider You requested.

If We approve the authorization, all services performed by the Out-of-Network Provider may be subject to a treatment plan approved by Us in consultation with Your PCP, the Out-of-Network Provider and You. Covered Services rendered by the Out-of-Network Provider will be processed as if they were provided by a Network Provider and the cost to You will be no greater than if You received care from a Network Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

In the event an authorization is not approved, any services rendered by an Out-of-Network Provider will not be covered.

We will reimburse You for Qualified Travel Expenditures. You may request reimbursement for Qualified Travel Expenditures by calling Antidote's Member Services Department at 1-888-623-3195. Mileage expenses will be reimbursed at the current IRS mileage standard for miles driven for medical purposes. You must support your claim for Qualified Travel Expenditures with the appropriate documentation (e.g., paid receipts). Requests for mileage reimbursement must include odometer readings or a reliable online mapping service to document the distance traveled. Other eligible travel expenses will be reimbursed in accordance with the Federal Travel Regulation in effect on the date expenses were incurred.

Rescission

A rescission of Your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide You with coverage, just as if You never had coverage under the Plan. Your coverage can only be rescinded if You (or a person seeking coverage on Your behalf), performs an act, practice, or omission that constitutes fraud; or unless You (or a person seeking coverage on Your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of Your Plan. Your Group can be terminated if the Group violates the participation or contribution rules, if applicable to Your Group coverage.

Your Group 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. See the APPEALS AND COMPLAINT PROCEDURES section for more information.

Coordination of Benefits

This Section applies if You are covered under another plan besides this Plan and determines the order of financial responsibility for how the benefits under the plans will be covered. If You are covered by more than one health benefit plan, You should file all claims with each plan.

Your primary plan is the health insurance policy that is typically responsible for paying first when a healthcare service is utilized. Your secondary plan generally covers Your remaining costs subject to the terms of Your Plan.

Coordination of benefits (COB) applies to medical services received under the terms of the Plan. Prescription medications are not subject to COB. If You choose to obtain medications other than through this Plan, amounts applied to Deductible, Copayments, or Coinsurance will not be reimbursed or accumulated towards Your Out-of-Pocket Limit under this Plan.

COB does not override Plan provisions, Exclusions, Prior Authorization or other requirements as noted in this Evidence of Coverage. All Plan terms and conditions apply whether this Plan is primary or secondary, including the requirement to receive all services through a Network Provider except as specifically noted in this Evidence of Coverage.

How COB works

When Antidote is Your primary Plan, We pay Your medical claims first as if there is no other coverage. When Antidote is Your secondary Plan:

- We pay benefits after the primary plan and reduce Our payment based on any amount the primary plan paid.
- Total payments from this Plan and Your other coverage will never add up to more than one hundred percent (100%) of the allowable expenses.

Determining Order of COB

COB Rule	Primary Plan	Secondary Plan
Non-Dependent or Dependent	Plan covering You as an employee, or Enrollee (not as a Dependent)	Plan covering You as a Dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year ("Birthday Rule")	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together	• Plan of parent responsible for health coverage in court order • Birthday Rule applies if both parents are responsible or have joint custody in court order • Custodial parent's plan if there is no court order	• Plan of other parent • Birthday Rule applies (later in the year) • Non-custodial parent's plan
Child – covered by individuals who are not parents (i.e., Step-parent or grandparent)	Same rule as parent	Same rule as parent
Active or inactive employee	Plan covering You as an active employee (or Dependent of an active employee)	Plan covering You as a laid off or retired employee (or Dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering You as an employee or retiree (or Dependent of an employee or retiree)	COBRA or state continuation coverage
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plan pays 50% of allowable expenses	Plans pays 50% of allowable expenses

SECTION V – COVERED HEALTH CARE SERVICES

Your Plan provides Covered Services. These are described in this section and appear in alphabetical order to make it easier to find what you're looking for. Covered Services are not listed as an Exclusion in Section VI Exclusions and Limitations, are not beyond any limits in the Schedule of Benefits and are Medically Necessary. See Section IV How Your Plan Works – Medical Necessity and Section XI Prior Authorization.

Accidental Dental

Coverage will be provided for dental service expenses when a Covered Person suffers an injury, after the Covered Person's Effective Date of coverage, that results in:

- Damage to his or her natural teeth; and
- Treatment of a fractured jaw.

Benefits are payable for the services of a Physician, dentist, or dental surgeon, provided the services are rendered for treatment of an accidental injury to sound natural teeth where the continuous course of treatment is started within six (6) months of the accident.

Ambulance Services

Emergency Ambulance transportation will be provided for Emergency Services by a licensed Ambulance service (either ground or air Ambulance) to the nearest Hospital where the required Emergency Services can be performed. Non-emergency Ambulance transportation will be provided by a licensed Ambulance service (either ground or air Ambulance, as We determine appropriate) between Facilities only when the transport meets one of the following:

- From an Out-of-Network Hospital to the closest Network Hospital when Covered Services are required.
- To the closest Network Hospital that provides the required Covered Services that were not available at the original Hospital.
- From a short-term Acute care Facility to the closest Network long-term Acute care Facility (LTAC), Network Inpatient rehabilitation Facility, or other Network sub-Acute Facility where the required Covered Services can be delivered.

Autism Spectrum Disorder

These Covered Services include Medically Necessary evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder:

- Outpatient physical Rehabilitation Services including:
  - Speech therapy or occupational therapy performed by a licensed therapist;
  - Clinical therapeutic intervention, defined as therapies supported by empirical evidence, which include but are not limited to Applied Behavioral Analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan.
- Mental/behavioral health Outpatient Therapy Services –performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation assessment, development, and oversight of treatment plans.

Bariatric Surgery

This Plan will cover bariatric surgery that modifies the gastrointestinal tract with the purpose of decreasing weight. Before pursuing bariatric surgery, a complete nutritional, behavioral, and medical evaluation must be completed, and requirements must be met. A Covered Person must meet the following medical criteria to be eligible for bariatric surgery:

- Have a body-mass index (BMI) equal to or greater than 35.
- Have at least one co-morbidity related to obesity.
- Have been previously unsuccessful with medical treatment for obesity and the patient's medical records must contain documentation regarding active participation within the last two years in one Provider-supervised weight management program for a minimum of six months without significant gaps. The weight management program must include monthly documentation of all of the following:
    - Weight
    - Current dietary program
    - Physical activity (e.g., exercise programs)

The Covered Person must be 18 years or older or have reached full expected skeletal growth. Only the following bariatric procedures are covered:

- Open roux-en-y gastric bypass (RYGBP), laparoscopic roux-en-y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB), open biliopancreatic diversion with duodenal switch (BPD/DS), laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS), and laparoscopic sleeve gastrectomy (LSG) when all required criteria are met.

Some bariatric procedures are not covered by the Plan. See Section V: Exclusions and Limitations.

Behavioral Health Care Services

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

Inpatient Stays. The Plan provides benefits for Behavioral Health Care Services You receive during an Inpatient admission or confinement for Acute Inpatient services for Mental Health Conditions and Substance Use services provided in a Hospital or other health care treatment Facility. These services include Inpatient psychiatric Hospitalization, Inpatient detoxification treatment, observation, and emergency evaluation and Stabilization.

Residential Treatment Services. The Plan provides benefits for Behavioral Health Care Services in a Residential Treatment program. These Covered Services can include individual and group psychotherapy, family counseling, nursing services, and pharmacological therapy in a congregate living community with twenty-four (24) hour support.

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

- Individual or group psychotherapy with Physicians, Psychologists, or other mental health professionals authorized or licensed by the state in which they practice (e.g., licensed clinical Social Workers, Clinical Nurse Specialists, certified alcohol and drug counselors);
- Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy, if required, must be a component of the Provider's treatment plan for the individual;

- Services of other staff (Social Workers, psychiatric nurses, and others) trained to work with psychiatric patients;
- Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes;
- Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals;
- 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 individual's care and treatment of his/her diagnosed psychiatric condition;
- Medically Necessary Diagnostic services related to mental health treatment.

Intensive Outpatient Services. The Plan provides benefits for Intensive Outpatient Treatment services offered by practice groups or Facilities that provide Behavioral Health Care Services. Intensive Outpatient Services programs are defined as those that provide nine (9) or more hours of treatment per week. The services may address Substance Use , mental or behavioral health issues, or both, which are dual diagnosis programs. 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.

Other Outpatient Services. The Plan provides benefits for office-based Behavioral Health Care Services. These include Diagnostic evaluation, screening, testing and assessments, counseling, individual psychotherapy, group psychotherapy, family psychotherapy, psychiatry, and crisis services. The services may be provided by a licensed mental health professional. Coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations, including Deductibles, Copayments, and Coinsurance provisions that are less favorable than the limitations that apply to a physical sickness as covered under this EOC.

Biomarker Testing

The Plan covers biomarker testing to help diagnose, treat, manage, or monitor a Covered Person's disease or condition. This testing guides treatment decisions when it is proven useful ("clinical utility") by medical and scientific evidence, including any of the following:

- Indications for tests approved by the Food and Drug Administration (FDA) or those related to FDA-approved Drugs.
- National or local Centers for Medicare & Medicaid Services (CMS) determinations.
- Nationally recognized clinical practice guidelines or consensus statements.

The Plan will provide coverage in a manner that limits disruptions in care, including minimizing the need for multiple biopsies or biospecimen samples.

Key Definitions

- Biomarker: A measurable characteristic used to indicate normal or abnormal biological processes, disease conditions, or responses to treatment. This includes gene mutations or protein levels.
- Biomarker Testing: Analyzing a patient's tissue, blood, or other samples to find biomarkers. This can include single tests, multiple tests in a panel, or whole genome sequencing.
- Clinical Utility: Means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.

- Consensus Statements: Recommendations made by an independent panel of experts, based on the best available evidence, to improve clinical care. These are developed using clear, transparent methods and include policies to manage conflicts of interest.
- Nationally Recognized Clinical Practice Guidelines: Evidence-based guidelines developed by independent organizations or medical societies. They set standards of care based on a thorough review of evidence and consider the benefits and costs of different care options to optimize patient care.

Biomarker testing may be subject to Prior Authorization or Utilization Review requirements. Any such requirements will be administered consistently with applicable Arizona law and will not impose standards or conditions for coverage that are different from those required by Arizona's biomarker testing coverage statutes. See Section XI for further information regarding requesting pre-service approval for biomarker testing. If a specific biomarker test is excluded from coverage, You or Your Authorized Representative may request an exception. To make a request, contact Us in writing or call the toll-free number on Your ID Card. We will notify You of Our determination within seventy-two (72) hours.

Chiropractic and Osteopathic Services

Diagnostic and treatment services provided by a Doctor of Chiropractic (chiropractor) or a Doctor of Osteopathy are covered. Coverage is limited to services performed in a Physician's office that are supportive or necessary to help a Covered Person achieve the physical state enjoyed before an injury or illness, which are determined to be Medically Necessary, and are generally furnished for the diagnosis or treatment of a neuromusculoskeletal condition associated with an injury or illness. Coverage includes examinations, adjustments, and manipulation by manual or mechanical means, and adjunctive physiotherapy.

Clinical Trials

Benefits are available under the Plan for services for routine patient care that is Medically Necessary and rendered as part of an approved clinical trial if the services are otherwise Covered Services under this Plan. For purposes of this EOC, coverage for clinical trials is in accordance with all applicable law, including 42 U.S.C.A. § 300gg-8 and A.R.S. § 20-1057.07. The following benefits shall not supplant any portion of the clinical trial that is customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources. Deductible, Coinsurance, and other Cost-Sharing requirements all apply to all benefits provided in connection with a clinical trial.

Approved clinical trial means:

The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in this state, that is for the treatment, palliation or prevention of cancer or a disabling or life-threatening disease or condition in humans and in which the scientific study includes all of the following:

- Specific goals.
- A rationale and background for the study.
- Criteria for patient selection.
- Specific directions for administering therapy and monitoring patients.
- A definition of quantitative measures for determining treatment response.
- Methods for documenting and treating adverse reactions.

The treatment is being provided as part of a study being conducted in a phase I, phase II, phase III or phase IV clinical trial.

The treatment is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following:

- One of the National Institutes of Health (NIH).
- A NIH cooperative group or center.
- The United States FDA in the form of an investigational new drug application.
- The United States Department of Defense.
- The United States Department of Veterans Affairs.
- A qualified research entity that meets the criteria established by the NIH for grant eligibility.
- A panel of qualified recognized experts in clinical research within academic health institutions in this state.

The proposed treatment or study has been reviewed and approved by an institutional review board of an institution in this state.

The personnel providing the treatment or conducting the study:

- Are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise.
- Agree to accept reimbursement as payment in full at the rates that are established by the organization and that are not more than the level of reimbursement applicable to other similar services provided by Network Providers.

There is no clear superior, non-investigational treatment alternative.

The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as efficacious as any non-investigational alternative.

Benefits do not, however, include the following:

- A health care service, item, or Drug that is the subject of the clinical trial or is provided solely to satisfy data collection and analysis needs for the clinical trial that is not used in the direct clinical management of the patient;
- Transportation, lodging, food, or other expenses for the patient, or a family Member or companion of the patient, that are associated with the travel to or from a Facility providing the clinical trial;
- An item or Drug provided by the clinical trial sponsors free of charge for any patient.
- A service, item, or Drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the clinical trial.
- Drugs administered or prescribed as part of, or in conjunction with a clinical trial protocol when the Drug is the subject of the trial.

Contraception

All FDA-approved contraception methods (identified on www.fda.gov) are approved for Covered Persons without Cost-Sharing as required under the Affordable Care Act. Some contraception methods are available through a Covered Person's medical benefit, including the insertion and removal of the contraceptive device, at no Cost Share to the Covered Person. Emergency contraception is available to Covered Persons without a prescription and at no Cost Share to the Covered Person.

Oral contraceptive coverage is provided in accordance with Affordable Care Act rules. If You are utilizing an oral contraceptive that is not on the Formulary or that is on a tier higher than the preventive tier, You or Your Provider can seek an exception for the contraceptive. We will provide You with an override so that non-Formulary or non-preferred medication will process at no cost to you.

Diabetes Services

Diabetes Self-Management Training and Education Services

"Diabetes self-management training and educational services" means instruction in an Inpatient or Outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent Hospitalizations and complications, when the instruction is provided in accordance with a program in compliance with the National Standards of Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Diabetes self-management training and educational services includes coverage for medical nutrition therapy when prescribed by a Health Care Provider and when provided by a certified, registered, or licensed Health Care Provider. Benefits also include medical eye exams (dilated retinal exams) and preventive foot care, and diabetic specific foot orthotics, orthopedic shoes, Medically Necessary custom molded shoes, depth shoes, inserts, modifications, footwear and podiatric appliances when Medically Necessary for the treatment of complications related to diabetes. Diabetic self-management supplies benefits for blood glucose control and testing including insulin syringes with needles, blood glucose and urine test strips, lancets and lancet devices, ketone test strips and glucose tablets, and single measurement glucose monitors, including those for the legally blind, excluding continuous glucose monitors, are described under the Prescription Drug benefit. An insulin pump and continuous glucose monitors are subject to all the conditions of coverage stated under Durable Medical Equipment (DME). Coverage for any other device, medication, equipment or supply for which coverage is required under Medicare guidelines pertaining to diabetes management is also included.

Dialysis

Medically Necessary Acute and chronic dialysis services are covered benefits unless other coverage is primary, such as Medicare for dialysis. There are two types of treatment: hemodialysis and peritoneal dialysis.

You may receive hemodialysis in an In-Network Dialysis Facility or peritoneal dialysis in Your home when Your In-Network Provider determines that home dialysis may be a better treatment option. Covered expenses include:

- Services provided in an Outpatient Dialysis Facility or when services are provided in the home;
- Processing and administration of blood or blood components;
- Dialysis services provided in a Hospital;
- Dialysis treatment of an Acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

After You receive appropriate training at a Dialysis Facility We designate, We also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis. Coverage is limited to the standard item of equipment or supplies that adequately meets Your medical needs. We will determine if equipment is made available on a rental or purchase basis. At Our option, We may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a Provider We authorize before the purchase.

Diagnostic Services

The Plan provides benefits for non-invasive Diagnostic Services, including:

- Biomarker testing as more fully described herein;
- X-ray and other radiology services, including mammograms, digital breast tomosynthesis,

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

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

Durable Medical Equipment (DME)

The rental (or, at Our option, the purchase) of Durable Medical Equipment prescribed by a Physician or other Provider. Durable Medical Equipment is equipment which can withstand repeated use (i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home). Examples include but are not limited to:

- Canes.
- Cochlear implants and batteries for cochlear implants.
- Commode chairs.
- Compression garments for treatment of lymphedema.
- Continuous glucose monitors.
- Continuous passive motion devices.
- Continuous Positive Airway Pressure (CPAP) devices.
- Crutches.
- Hospital beds.
- Infusion pumps.
- Nebulizers.
- Oxygen equipment.
- Patient lifts.
- Pressure-reducing support surfaces.
- Suction pumps.
- Traction equipment.
- Trusses.
- Walkers.
- Manual Wheelchairs.

Rental costs must not be more than the purchase price. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. If You purchase an item that exceeds the minimum specifications for Your needs, We will pay only the amount that We would have paid for the item that meets the minimum specifications, and You will be responsible for paying any difference in cost.

Coverage is for standard equipment only. We cover the cost of repair or replacement when made necessary by normal wear and tear. We do not cover the cost of repair or replacement that is the result of misuse or abuse by You.

We do not cover over-the-counter Durable Medical Equipment. We do not cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of Durable Medical Equipment. We also do not cover the customization of vehicles, vehicle lifts for wheelchairs and/or scooters, or modifications of the Your home (e.g., ramp installation).

Medical Supplies that are used with covered DME are covered when the supply is necessary for the effective use of the item/device (e.g., oxygen tubing or mask, batteries for power wheelchairs and prosthetics, or tubing for a delivery pump).

Emergency Services

Services which We determine to meet the definition of Emergency Services will be covered, whether the care is rendered by a Network Provider or Out-of-Network Provider. Emergency Benefits are provided for treatment of Emergency Medical Conditions and emergency screening and stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for emergency care include Facility costs and Physician Services, and supplies and Prescription Drugs charged by that Facility. Care and treatment provided once You are Stabilized is no longer considered emergency care.
Continuation of care from an Out-of-Network Provider beyond that needed to evaluate or Stabilize Your condition in an emergency will be covered as an Out-of-Network service unless We authorize the continuation of care and it is Medically Necessary.

When You are admitted as an Inpatient directly from an emergency room, the entire visit, including Emergency Services received in the emergency room, will be treated as an Inpatient stay, and the applicable Deductible, Copayment and Coinsurance will apply.

For Emergency Services, Prior Authorization is not required. If You are admitted to an Inpatient Hospital and Your condition has Stabilized, You or the Hospital should notify Us as soon as reasonably possible of the Inpatient admission so that We may coordinate post-stabilization care and concurrently review the Medical Necessity of the continued Inpatient stay. It is recommended that You or the Hospital notify Us within 24 hours of the point Your treating Provider has determined that Your condition is stable. Notification is not a condition of coverage or payment for Emergency Services or emergency stabilization services.

The No Surprises Act (NSA), enacted January 1, 2022, protects You from receiving surprise medical bills under the following circumstances:

- Most Emergency Services, including post-stabilization services.
- Non-emergency care from Out-of-Network Providers, such as anesthesiologists and pathologists in In-Network facilities.
- Out-of-Network air Ambulance companies.

Surprise bills may occur in three distinct circumstances:

- During a medical emergency where care is imminent and necessary, and YOU do not have time to research which facilities and Providers are In-Network. Along with traditional emergency rooms and freestanding emergency facilities, bills from emergency air Ambulance services are also included.
- Post-stabilization services following emergency care in a Hospital. This refers to care administered after You are in stable condition following an emergency. Post-stabilization services provided at an Out-of-Network Facility are no longer considered emergency care once Your treating Provider determines You can be moved safely to an In-Network Facility using non-medical transport, a Facility is available and accepts the transfer, and the transfer will not cause unreasonable burdens to You. You must give written consent to be transferred.
- Non-Emergency Services provided at In-Network facilities, such as Out-of-Network anesthesiologists, radiologists, and other ancillary care Providers whom You did not select but who provide services for the In-Network Facility. These Providers bill for services separately from the Facility and may not contract with the Antidote Health Plan.

The NSA protects You from Balance Billing, which is when an Out-of-Network Provider may charge You the difference between what We paid and the amount billed by the Out-of-Network Provider.

The NSA does not protect You from bills from the following;

- Ground Ambulance transport.
- In-Network Providers and facilities that are contracted by Us.
- Out-of-Network Providers who do not practice at an In-Network Facility.
- Certain medical facilities, including Urgent Care Centers, birthing centers, Hospice facilities, addiction treatment centers, and nursing homes.

If You receive a surprise medical bill for amounts that are not Your responsibility, please call Us at 888-623-3195.

Family Planning Services

Covered Services and supply expenses for family planning include:

- Medical history review.
- Physical examinations.
- Laboratory tests related to physical examinations.
- Contraceptive counseling.
- All FDA-approved contraception methods are covered without Cost-Sharing as outlined at www.fda.gov (see “Contraception” section above). This benefit contains both pharmaceutical and medical methods, including, but not limited to:
    - Intrauterine devices (IUD), including insertion and removal;
    - Barrier methods including: male and female condoms (Rx required from Provider, limited to thirty (30) per month), diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, and spermicide alone;
    - Oral contraceptives including the pill (combined pill and extended/continuous use), and the mini pill (Progestin only), patch;
    - Other hormonal contraceptives, including inserted and implanted contraceptive devices, hormone contraceptive injections, and the vaginal contraceptive ring;

    - Emergency contraception (the morning after pill);
    - FDA-approved tubal ligation; and
    - For Prescription Drug contraceptives.
- Vasectomy and services related to this procedure.

Contraceptives and services related to use of contraceptives are covered without Cost-Sharing. Please also refer to the Preventive Care Services section.

Habilitative Services

For purposes of this Benefit, Habilitative Services means skilled care services that are part of a prescribed treatment plan, plan of care, or Medically Necessary maintenance program to help a Covered Person with a disabling condition to keep, learn or improve skills and functioning for daily living. We will decide if benefits are available by reviewing both the skilled nature of the service and the need for Provider-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered Habilitative Services.

Habilitative Services include:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

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

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed Social Worker or licensed Psychologist; and
- The initial or continued treatment must not be Experimental or Investigative. Benefits for Habilitative Services do not apply to health care services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not Habilitative Services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a Habilitative Service. When the Covered Person does not demonstrate continued maintenance or progress under a treatment plan, a service that was previously a Habilitative Service will no longer be considered by Us to be a Habilitative Service.

Hearing Aid

- We provide wearable Hearing Aids and related services to individuals up to age 18 or up to age 21 if Covered Person is still attending high school.
- One Hearing Aid per hearing-impaired ear, up to $2,200 every 36 months and You were verified as being deaf or hearing impaired by a licensed audiologist, otolaryngologist or other licensed Physician.
- You may choose a higher priced Hearing Aid and must pay the difference in cost above the $2,200 required coverage without any financial or contractual penalty to You or to the Provider of the Hearing Aid.
- We will only provide coverage for Hearing Aids that are considered medically appropriate to meet

Your needs, according to professional standards established by the state speech and hearing professionals' boards.

- Coverage includes:
    - Fitting and dispensing services,
    - Provision of ear molds as necessary to maintain optimal fit,
    - Any related services provided by a licensed health care provider.

Home Health Care

We cover services that are performed by a Home Health Care Agency or other Provider in Your residence. Home Health Care includes professional, technical, health aide services, supplies and medical equipment. You must be confined to the home for medical reasons and be physically unable to obtain needed medical services on an Outpatient basis.

Covered Services include:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- Medical/Social services.
- Diagnostic Services.
- Nutritional guidance.
- Home Health Aide Services. The Covered Person must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must have a medical need as determined by a Physician or other licensed practitioner authorized under Arizona law and provided pursuant to a written plan of care. A clinical review of the plan of care must be reviewed by You and the Provider at thirty-day (30) intervals. Services performed by Home Health Care organizations or agencies require Prior Authorization.
- Therapy Services.
- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).

Non-Covered Services include:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Diabetes Services).
- Physician, nurse practitioner, physician assistant, and other professional provider services are not covered as part of a Home Health Care Agency's charges. Such professional services may be covered separately when billed by the rendering provider and otherwise covered under the applicable benefits of this Plan.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances, and devices.)
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Agency.
- Services provided by 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.

Home Health Care services may include services of a person who is a member of Your family or Your Dependent's family or who normally reside in Your house or Your Dependent's house provided such person has contracted with Antidote to perform such services. Except for Emergency Services, services from an Out-of-Network Provider are not covered.

Hospice Care

The Plan provides benefits for Hospice Care when You have a terminal illness and elect to receive hospice services through a licensed hospice program. Hospice Care may be provided in Your home, a hospital, a nursing facility, or another appropriate setting consistent with the hospice plan of care.

To be eligible for a Hospice Care program, You must be diagnosed with a terminal illness and have a life expectancy of approximately six (6) months or less , if the illness runs its normal course, as certified by Your attending Physician, nurse practitioner, or other authorized health care provider in accordance with applicable law and the requirements of the hospice program. Hospice benefits may continue beyond six (6) months when You continue to meet the hospice program's eligibility requirements. Hospice services must be provided by, arranged through, or authorized by the hospice program and included in the hospice plan of care. Hospice services require Prior Authorization.

Hospice services that qualify as Covered Services include the following:

- Inpatient care.
- Outpatient Services.
- Physician and other professional Provider services or other licensed practitioner participating in the hospice plan of care and related to the terminal illness.
- Services of a Psychologist, Social Worker or family counselor for individual and family counseling.
- Skilled nursing services provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), when furnished as part of the hospice plan of care.
- Diagnostic Services necessary for the palliation and management of the terminal illness.
- Physical, speech, inhalation and respiratory therapies, when furnished as part of the hospice plan of care.
- Medical supplies, Durable Medical Equipment, and appliances related to the terminal illness.
- Counseling services.
- Inpatient Stay at a Hospice Facility.
- Prescription Drugs provided by or arranged through the Hospice program and related to the palliative treatment, pain control, or symptom management of the terminal illness.
- Hospice services provided in Your home as part of the hospice plan of care.

Coverage for Hospice Care is provided when arranged through and furnished under the Hospice program. Coverage is subject to the Exclusions and Limitations described in this Evidence of Coverage.

Hospital – Inpatient Stay

Services and supplies provided during an Inpatient stay in a Hospital or birthing center. Benefits are available for:

- Charges from a Hospital or Skilled Nursing Facility (SNF) or other Provider as authorized by Us for room, board, and general nursing services, as follows:
  - A room with two (2) or more beds.
  - A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that You use a private room for isolation and no isolation Facilities are available.
  - A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care of critically ill patients.
- Ancillary (related) services, as follows:

- Charges for operating, delivery and treatment rooms and equipment.
- Prescription Drugs.
- Anesthesia, anesthesia supplies and services.
- Medical and surgical dressings, supplies, casts, and splints.
- Diagnostic Services.
- Therapy Services.
- Biologicals.
- Fluids.
- Blood and blood products.
- Chemotherapy.
- Special diets.
- Laboratory and radiology services and other Diagnostic and therapeutic services.
- Anesthesia and associated services.
- Inhalation therapy.
- Radiation therapy.
- Admission kit and other services which are customarily provided in acute care hospitals.

- Physician Services You receive during an Inpatient stay.

Infertility Services

We cover 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 diagnose or treat a medical condition that results in infertility (e.g., endometriosis, blockage of fallopian tubes, varicocele, etc.).

The following procedures are not covered: artificial insemination, IVF, GIFT, ZIFT, services for procurement and storage of donor semen/eggs, and Drugs for infertility treatment.

Infusion Therapy

We cover infusion therapy which is the administration of Drugs using specialized delivery systems which otherwise would have required You to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Provider and provided in an office or by an agency licensed or certified to provide infusion therapy.

We cover home infusion therapy if Your Network Provider obtains Prior Authorization (if applicable). Benefits for home infusion therapy include a combination of nursing, DME and Drug services which are delivered and administered intravenously in the home. Home infusion therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain management and chemotherapy.

Note: For Specialty Drugs prescribed by a Network Provider, Prior Authorization is required if the cost of the Specialty Drug exceeds $250. Depending upon the prescribed Specialty Drug, You may be contacted by Case Management to discuss alternative Drugs and sites of care for Your infusion therapy. When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, We will not provide coverage for an infusion or injection of a specialty Drug provided in the Outpatient department of a Hospital if the Drug could be safely provided in a Physician’s office, the home setting or an Outpatient infusion center.

Home infusion therapies that require Prior Authorization are:

- Antibiotic therapy;
- Antifungals;
- Antivirals;
- Hydration;
- Pain Management;
- Total Parenteral Nutrition.

Mammography Screening

Covered Service expenses under this benefit are provided for screening mammography, diagnostic breast examinations, and supplemental breast examinations, as Medically Necessary to detect breast cancer in Covered Persons in accordance with applicable state and federal law.

A screening mammography means a preventive breast cancer screening examination performed on an asymptomatic individual for the purpose of detecting breast cancer at an early stage before signs or symptoms are present. Screening Mammography includes digital mammography, digital breast tomosynthesis (3-D mammography), and other generally accepted mammographic screening technologies that are medically appropriate and covered under applicable state and federal law.

A diagnostic mammography means a Medically Necessary and appropriate examination of the breast that may include MRI, ultrasound, or other medically appropriate imaging used to evaluate an abnormality identified or suspected through breast cancer screening or detected through another method of examination.

A supplemental mammography means a Medically Necessary and appropriate examination of the breast that may include MRI, ultrasound, or other medically appropriate imaging used to screen for breast cancer based on personal history, family history, dense breast tissue, or other factors that increase Your risk of breast cancer. Coverage also includes the professional interpretation of film.

Preventive screening mammography and additional screening services, including diagnostic breast examinations and supplemental breast examinations, shall be provided at no Cost Share to You when obtained from a Network Provider.

Coverage includes:

- One screening mammography every year, including digital breast tomosynthesis; and
- A diagnostic breast examination when Medically Necessary and clinically appropriate when used to:
    - Evaluate an abnormality identified or suspected as a result a breast cancer screening examination; or
    - An abnormality detected by another method of examination.
- Supplemental breast cancer screening for an adult woman who meets either of the following conditions:
    - The woman’s screening mammography demonstrates, based on the Breast Imaging Reporting and Data System (BI-RADS) established by the American College of Radiology, that You have dense breast tissue; or
    - You are at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by Your Provider.

Mastectomy Benefits

Covered Service expenses for a mastectomy include reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance and post-operative breast prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas. Post-mastectomy surgical bras, camisoles and external prosthetics that meet external prosthetic placement needs and are determined by Us or Our Utilization Review agent to be Medically Necessary are covered as part of this benefit.

Maternity Services

The Plan provides benefits for Maternity Services. Maternity Services include Inpatient services, Outpatient Services, Provider home visits and office services. These services are used for normal or complicated pregnancy, miscarriage, Therapeutic Abortion (abortion recommended by a Provider), and ordinary routine nursery care for a healthy newborn. If You are pregnant when Your benefits begin, please refer to the Continuity of Care section in Section III: HOW YOUR PLAN WORKS.

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 requires Prior Authorization. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if You consent to such shorter stay and Your attending Physician, or if a certified nurse-midwife is attending You in collaboration with a Physician, the certified nurse-midwife determines further Inpatient postpartum care is not necessary for You or Your newborn Child, provided that the following conditions are met:

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

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

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

delivery care visits by Your Physician or nurse performed no later than seventy-two (72) hours following You and Your newborn Child's discharge from the Hospital. Covered Services for at-home post-delivery care visits include but are not limited to:

- parent education;
- assistance and training in breast or bottle feeding; and
- performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for You or Your newborn Child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. At Your discretion, this visit may occur at the Physician's office.

For adopted Children: Charges incurred at the birth for the delivery of a Child only to the extent that they exceed the birth mother's coverage, if any, provided:

- That Child is legally adopted by You within one (1) year from date of birth;
- You are legally obligated to pay the cost of the birth;
- You notify Us of the adoption within sixty (60) days after approval of the adoption or a change in the insurance policies, plans, or company; and
- You choose to file a claim for such expenses subject to all other terms of these medical benefits.

Notification and Coverage of Pregnancy Surrogacy

You should notify Us immediately if You as the Covered Person intend to enter into an agreement to be a surrogate mother or have agreed to be a surrogate mother. A Covered Person serving as a surrogate or gestational carrier remains eligible for all otherwise Covered Services, including Medically Necessary maternity, pregnancy, delivery, postpartum, behavioral health, and complication-related care, subject to the terms of this Policy. This Policy does not cover contractual surrogacy arrangement expenses, compensation paid to a surrogate, donor gametes, embryo transfer services, fertility services otherwise excluded under this Policy, legal fees, agency fees, or services provided to a non-Covered Person.

Medical and Surgical Expense Benefits

Medical Covered Service expenses include, but are not limited to, charges:

- For surgery in a Physician's office or at an Outpatient surgical Facility, including services and supplies.
- Made by a Provider for professional services, including surgery.
- Made by an assistant surgeon.
- For the professional services of a medical practitioner.
- For dressings, crutches, orthopedic splints, braces, casts, or other necessary medical supplies.
- For Diagnostic Services using radiologic, ultrasonographic, or laboratory services.
- For chemotherapy (including oral chemotherapy) and radiation therapy or treatment. We shall not provide coverage or impose Cost-Sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or Cost-Sharing it imposes for intravenously administered or injected cancer medications.
- For hemodialysis, and the charges by a Hospital for processing and administration of blood or blood components.
- For the cost and administration of an anesthetic.
- For oxygen and its administration.
- Excluding tooth extraction, We will treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint.
- For reconstructive breast surgery charges as a result of a partial or total mastectomy for breast cancer.

- For routine patient care for patients enrolled in an eligible cancer clinical trial.
- For the following types of tissue transplants:
  - Cornea transplants.
  - Artery or vein grafts.
  - Heart valve grafts.
  - Prosthetic tissue replacement, including joint replacements.
  - Implantable prosthetic lenses, in connection with cataracts.
- Family planning for certain professional Provider contraceptive services and supplies, including but not limited to, vasectomy, tubal ligation, and insertion or extraction of FDA-approved contraceptive devices.
- Allergy testing, injections, and serum.
- X-ray and other radiology services.
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Positron emission tomography (PET scanning).
- For routine care costs that are incurred in the course of a clinical trial that is deemed an Experimental or Investigative treatment if the services provided are otherwise considered Covered Services under the contract.
- Cytologic screenings for cervical cancer.
- Cochlear implants.
- Vision correction as a result of surgery or accident.
- Medically Necessary Telehealth services to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the Provider for Telehealth is at a distant site. Telehealth services are subject to the same clinical and Utilization Review criteria, Plan requirements, limitations, and Cost-Sharing as the same health care services when delivered to an insured in person. Medically Necessary virtual care encompasses Telehealth services. This is provided on the same basis and to the same extent (included Cost Shares) for the provision of in-person health care services.
- Medically Necessary services for complications arising from medical and surgical conditions.

Medical and Surgical Supplies

Coverage for non-durable medical supplies and equipment for management of disease and treatment of medical and surgical conditions.

Covered Services and supplies may include, but are not limited to:

- Allergy serum extracts.
- Chem strips, Glucometer, Lancets.
- Clinitest.
- Needles/syringes.
- Medically Necessary ostomy bags and supplies.

Exclusions:

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

- Adhesive tape, band aids, cotton tipped applicators.
- Arch supports.
- Doughnut cushions.
- Hot packs, ice bags.
- Vitamins.
- Med-injectors.

- Items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Medical Foods for Inherited Metabolic Disorders

We cover medical foods and formulas for inherited metabolic disorders. Inherited Metabolic Disorder is a disease caused by an inherited abnormality of body chemistry that meets the following:

- The disorder is one of the diseases tested for under the newborn screening program required under Arizona state law;
- The disorder requires the Covered Person to consume medical foods throughout his or her life in order to avoid serious mental or physical impairment; and
- The disorder must involve amino acid, carbohydrate, or fat metabolism and have medically standard methods of Diagnosis, Treatment, and monitoring, including qualification of metabolites in blood, urine, or spinal fluid, or enzyme or DNA confirmation in tissues.

Medical foods are modified low-protein foods and metabolic formulas that are:

- Essential to the Covered Person's optimal growth, health, and metabolic homeostasis;
- Formulated to be consumed or administered through the gastrointestinal tract under the supervision of a Physician or registered nurse;
- Prescribed for the medical and nutritional management of a Covered Person who has limited capacity to metabolize foodstuffs or certain nutrients contained in foodstuffs, or who has other specific nutrient requirements as established by medical evaluation;
- Processed or formulated to the deficient in one or more of the nutrients present in typical foodstuffs (metabolic formula only); and
- Processed or formulated to contain less than 1 gram of protein per unit of serving (modified low-protein foods only).

Medical Foods for Inherited Metabolic Disorders are not subject to the annual deductible.

Eosinophilic Gastrointestinal Disorder Services

We cover formula (amino-acid based) for Eosinophilic Gastrointestinal Disorder (EGID) that is available from In-Network Providers for Covered Persons who are:

- At risk of mental or physical impairment if deprived of the formula;
- Diagnosed with EGID;
- Under the continuous supervision of a Physician or registered nurse.

Eosinophilic Gastrointestinal Disorder Services are not subject to the annual deductible.

Mental Health Condition and Substance Use Services

Prior Authorization is required for certain Mental Health Condition and Substance Use services. Emergency Services never require Prior Authorization. Covered Services include services for Mental Health Conditions and Substance Use. This includes services for all mental conditions identified as "Mental Disorders" in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including the diagnosis and Medically Necessary treatment of Substance Use, Severe Mental Illness (SMI) of a person of any age, and Serious Emotional Disturbances (SED) of a Child as defined by the most recent edition of the DSM. We comply with applicable federal law governing mental health parity, including but not limited to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Mental health Covered Services include the following:

- Inpatient services in a licensed, Network Hospital, Residential Treatment center, or any Facility that We must cover per state law. Inpatient benefits include:
  - Inpatient Facility services for Acute Mental Health Conditions, including Physician Services;
  - Inpatient psychiatric observation for Acute psychiatric crisis, including Physician Services, medications, and testing;
  - Residential Treatment.
- Outpatient office visits
  - Individual and group mental health evaluation and treatment;
  - Outpatient Services for monitoring Drug therapy;
  - Mental/behavioral health Outpatient Therapy Services for Autism Spectrum Disorder (See the Autism Spectrum Disorder section above).
- Outpatient Items and Services
  - Partial Hospitalization/Day Treatment;
  - Short-term intensive Outpatient psychiatric treatment;
  - Outpatient psychiatric observation for an Acute psychiatric crisis;
  - Psychological testing and neuropsychological testing to evaluate a mental condition;
  - Behavioral Health Therapy Home Visit for Autism Spectrum Disorder.
- Substance Use (Chemical Dependency) Services include the following:
  - Inpatient services in a licensed, Network Hospital, Residential Treatment center or any Facility that We must cover per state law. Inpatient benefits include:
    - Services for detoxification, including Physician Services;
    - Transitional residential recovery services for assistance with post-detoxification treatments.
  - Outpatient office visits including office visits and treatment in an Outpatient department of a Hospital or Outpatient Facility, such as:
    - Individual and group chemical dependency counseling; and medical treatment for withdrawal symptoms.
  - Outpatient Items and Services
    - Day treatment program for Substance Use;
    - Intensive Outpatient Treatment for Substance Use;
    - Ambulatory detoxification;
    - Non-emergency psychiatric transportation.
- Biofeedback for pain management.
- Covered Services for mental health includes certain medications and testing or diagnosis covered under the medical benefit.

Inpatient services coverage includes individual psychotherapy, group psychotherapy, psychological testing, and counseling with family members to assist with the patient's diagnosis and treatment, and convulsive therapy, detoxification, and rehabilitation treatment; Hospital and Inpatient professional charges in any Hospital or Facility required by state law.

Outpatient services coverage includes diagnosis and treatment of psychiatric conditions, individual and group psychotherapy, psychological testing, office visits, Outpatient Facility and Provider charges, and medication management checks. Providers who can provide Covered Services include, but are not limited to:

- Psychiatrist;

- Psychologist;
- Licensed clinical Social Worker (L.C.S.W.);
- Mental health Clinical Nurse Specialist;
- Licensed marriage and family therapist (L.M.F.T.);
- Licensed Professional Counselor (L.P.C);
- Other recognized Substance Use professionals.

Orthotic Devices

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

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

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

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

Outpatient Services

The Plan provides benefits for Outpatient Services. Outpatient Services include Facility, ancillary, Facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider (including an Ambulatory Surgical Center) as determined by the Plan. These Facilities may include a non-Hospital site providing Diagnostic Services, Therapy Services, surgery, or rehabilitation, or other Provider Facility as determined by us. Any Coinsurance will still apply to these health care services.

Pediatric Vision Services

The Plan provides the following pediatric vision benefits for Children up to the end of the month in which a Child turns 19 years of age:

- Vision exam – one (1) per Benefit Period. The exam is comprehensive and includes dilation, if professionally indicated.
- Prescription lenses and frames – standard prescription lenses– one (1) per Benefit Period. We will pay for one (1) standard frame per Benefit Period.
    - Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription

sunglass lenses. Polycarbonate lenses are covered in full for Children. All lenses include scratch resistant and UV coating with no additional cost.

- Prescription contact lenses – 1 item covered in full once every Benefit Period –in lieu of eyeglasses. Items include:
  - Standard (one pair annually) = 1 contact lens per eye (total 2 lenses)
  - Monthly (six-months' supply) = 6 lenses per eye (total 12 lenses)
  - Bi-weekly (three-months' supply) = 6 lenses per eye (total 12 lenses)
  - Dailies (three-months' supply) = 90 lenses per eye (total 180 lenses)
- Low Vision – Low vision is covered if vision loss is sufficient to prevent reading and performing daily activities. Coverage includes an annual low vision evaluation. Network Providers will obtain the necessary Prior Authorization for these services. We also cover low vision aids, including prescription services and optical/non-optical aids.
- We also cover the following optical lenses and treatments:
  - Ultraviolet Protective Coating
  - Blended Segment Lenses
  - Intermediate Vision Lenses
  - Standard Progressives
  - Premium Progressives (Varilux®, etc.)
  - Photochromic Glass Lenses
  - Plastic Photosensitive Lenses (Transitions®)
  - Polarized Lenses
  - Standard Anti-Reflective (AR) Coating
  - Premium AR Coating
  - Ultra AR Coating
  - Hi-Index Lenses

Exclusions:

The Plan does not cover:

- Services provided by an Out-of-Network Provider.
- Services, treatments, or materials not specifically listed as a Covered Service.
- Services or materials which are rendered prior to the Effective Date or incurred after the termination date.
- Services and materials not meeting accepted standards of optometric practice.
- Services and materials resulting from Your failure to comply with professionally prescribed treatment.
- Telephone consultations.
- Any charges for failure to keep a scheduled appointment.
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.
- Office infection control charges.
- Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts.
- State or territorial taxes on vision materials and services performed.
- Medical treatment of eye disease or sickness or injury.
- Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
- Visual therapy.
- Vision orthoptic training.
- Special lens designs or coatings other than those listed as Covered Services.
- Replacement of lost or stolen eyewear.

- Non-prescription (Plano) lenses.
- Two pairs of eyeglasses in lieu of bifocals.
- Services not performed by licensed personnel.
- Prosthetic devices and services.
- Insurance of contact lenses.

Pediatric Vision services may include services of a Provider who is a member of Your family or Your Dependent's family or who normally resides in Your house or Your Dependent's house provided such person has contracted with Antidote to perform such services. Except for Emergency Services, services from an Out-of-Network Provider are not covered.

Preventive Care Services (Covered without Cost-Sharing)

Preventive care services provided on an Outpatient basis at a Physician's office, an alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, Children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
    - Contraceptive devices, including the insertion or removal of, and any Medically Necessary consultations, examinations, or procedures associated with, the use of intrauterine devices, diaphragms, injectable contraceptives, and implanted hormonal contraceptives.
    - Benefits include one screening mammography, including digital breast tomosynthesis, in adult women.
    - Benefits for a diagnostic breast examination are included when Medically Necessary and clinically appropriate when used to evaluate an abnormality identified or suspected as a result a breast cancer screening examination or an abnormality detected by another method of examination.
    - Benefits for supplemental breast cancer screening are included for an adult woman who:
        - Has a screening mammography that shows dense breast tissue;
        - Is at increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by Your Provider.
- Screening for nicotine or tobacco use; and
- For those who use nicotine or tobacco products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
    - Four (4) nicotine or tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling, and individual counseling) without Prior Authorization; and
    - All Food and Drug Administration (FDA) approved nicotine or tobacco cessation medications (including both prescription and over-the-counter medications) for a ninety

(90) day treatment regimen when prescribed by a healthcare Provider without Prior Authorization.

Benefits defined under the Health Resources and Services Administration (HRSA) requirement include one breast pump per pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Provider. You can find more information on how to access benefits for breast pumps by contacting Us at antidotehealth.com or the telephone number on Your ID Card. Prenatal and postnatal lactation support and counseling from In-Network obstetricians and Providers are also included. To locate Network Providers that provide these services, please visit antidotehealth.com.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any Deductibles, Cost-Sharing percentage provisions, and Copayment amounts under the contract when the services are provided by a Network Provider. If a service is considered Diagnostic or non-preventive, Your Plan Copayment, Coinsurance and Deductible will apply.

If a Covered Person receives any other Covered Service during a preventive care visit, the Covered Person may be responsible to pay the applicable Deductible, Copayment and Coinsurance for those services.

Covered Preventive Services for Adults include:

- Abdominal Aortic Aneurysm one-time screening for adults of specified ages who have ever smoked;
- Alcohol misuse screening and counseling;
- Aspirin used to prevent cardiovascular disease for adults of certain ages;
- Blood pressure screening for all adults;
- Cholesterol screening for adults of certain ages or at higher risk;
- Colorectal Cancer screening for adults over 50;
- Depression screening for adults;
- Type 2 Diabetes screening for adults with high blood pressure;
- Diet counseling for adults at higher risk for chronic disease;
- Hepatitis B screening for adults at high risk, including adults from countries with 2% or more Hepatitis B prevalence, and U.S.-born adults not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence;
- Hepatitis C screening for adults at increased risk, and one time for everyone born 1945-1965;
- HIV screening for all adults at higher risk and medically appropriate HIV pre-exposure prophylaxis (PrEP) and related services to the extent those ancillary services are classified as Preventive Care under the Affordable Care Act.
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Diphtheria;
    - Hepatitis A;
    - Hepatitis B;
    - Herpes Zoster;
    - Human Papillomavirus;
    - Influenza (Flu Shot);
    - COVID-19;
    - Measles, Mumps, Rubella;
    - Meningococcal;
    - Pneumococcal;
    - Tetanus, Diphtheria, Pertussis; and

    - Varicella.
- Lung cancer screening for adults 55-80 at high risk for lung cancer because the adult is a heavy smoker or has quit in the past fifteen (15) years;
- Obesity screening and counseling for all adults;
- Prostate screening. One (1) prostate specific antigen (PSA) test in a 12-month period and digital rectal examination for Covered Persons age 40 and older, and Covered Persons under 40 if at high risk due to family history, race, or previous borderline PSA levels.
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
- Tobacco or nicotine use screening for all adults and cessation interventions for tobacco or nicotine users; and
- Syphilis screening for all adults at higher risk.

Covered Preventive Services for Women and Pregnant Women include:

- Anemia screening on a routine basis for pregnant Covered Persons;
- Urinary tract or other infection screening for pregnant Covered Person;
- BRCA counseling about genetic testing for Covered Persons at higher risk;
- One (1) cytologic screening per year or more often if recommended by a Provider;
- Preventive mammography screening and Diagnostic imaging performed on dedicated equipment for diagnostic purposes on Referral by a Covered Person's Physician, subject to all of the terms and conditions of this Group Policy, including:
    - A mammogram
    - Digital breast tomosynthesis, magnetic resonance imaging, ultrasound or other modality and at such age and intervals as recommended by the national comprehensive cancer network. This includes patients at risk for breast cancer who have a family history with one or more first or second degree relatives with breast cancer, prior diagnosis of breast cancer, positive testing for hereditary gene mutations or heterogeneously or dense breast tissue based on the breast imaging reporting and data system of the American College Of Radiology;
- Breast cancer chemoprevention counseling for Covered Persons at higher risk;
- Breastfeeding comprehensive support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing Covered Persons;
- Cervical cancer screening for sexually active Covered Persons;
- Chlamydia infection screening for younger Covered Persons and other Covered Persons at higher risk;
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a Health Care Provider for Covered Persons with reproductive capacity (not including abortifacient Drugs);
- Domestic and interpersonal violence screening and counseling for all Covered Persons;
- Folic acid supplements for Covered Persons who may become pregnant;
- Gestational diabetes screening for Covered Persons 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
- Gonorrhea screening for all Covered Persons at higher risk;
- Hepatitis B screening for pregnant Covered Persons at their first prenatal visit;
- Prenatal vitamins;
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active Covered Persons;
- Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three (3) years for Covered Persons with normal cytology results who are 30 or older;
- Coverage for Medically Necessary bone mass measurement and for diagnosis and treatment of osteoporosis;
- Rh Incompatibility screening for all pregnant Covered Persons and follow-up testing for Covered

Persons at higher risk;
- Tobacco or nicotine use screening and interventions for all Covered Persons, and expanded counseling for pregnant tobacco users;
- Sexually Transmitted Infections (STI) counseling for sexually active Covered Persons;
- Syphilis screening for all pregnant Covered Persons or other Covered Persons at increased risk; and
- Wellness visits to obtain recommended preventive services.

Covered Preventive Services for Children include:

- Alcohol and Drug use assessments for adolescents;
- Autism screening for Children at 18 and 24 months;
- Behavioral assessments for Children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Blood pressure screening for Children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Cervical dysplasia screening for sexually active adolescents;
- Congenital hypothyroidism screening for newborns;
- Depression screening for adolescents;
- Developmental screening for Children under age 3, and surveillance throughout childhood;
- Dyslipidemia screening for Children at higher risk of lipid disorders. Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Fluoride chemoprevention supplements for Children without fluoride in their water source;
- Gonorrhea preventive medication for the eyes of all newborns;
- Hearing screening for all newborns;
- Height, weight, and body mass index measurements for Children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Hematocrit or hemoglobin screening for Children;
- Hemoglobinopathies or sickle cell screening for newborns;
- Hepatitis B screening for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11-17 years;
- HIV screening for adolescents at higher risk;
- Hypothyroidism screening for newborns;
- Immunization vaccines for Children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    a. Diphtheria, Tetanus, Pertussis;
    b. Haemophilus influenzae type b;
    c. Hepatitis A;
    d. Hepatitis B;
    e. Human Papillomavirus;
    f. Inactivated Poliovirus;
    g. Influenza (Flu Shot);
    h. COVID-19;
    i. Measles, Mumps, Rubella;
    j. Meningococcal;
    k. Pneumococcal;
    l. Rotavirus; and
    m. Varicella.
- Iron supplements for Children ages 6 to 12 months at risk for anemia;

- Lead screening for Children at risk of exposure;
- Medical history for all Children throughout development. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Obesity screening and counseling;
- Oral health risk assessment for young Children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years;
- Phenylketonuria (PKU) screening for this genetic disorder in newborns;
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
- Tuberculin testing for Children at higher risk of tuberculosis. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years; and
- Vision screening for all Children.

Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears, and nose.
- Breast prosthesis and wigs as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras.
- Wigs or hair pieces for alleviation or correction of alopecia as a result of chemotherapy, radiation therapy, and second or third degree burns. Coverage is limited to the first wig after active cancer treatment or burn injury, not to exceed one (1) per Benefit Period.
- Terminal devices such as hand or hook.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Service for which benefits are available under the applicable medical/surgical Covered Service categories in this Group Policy.

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

The prosthetic device must be ordered or provided by, or under the direction of a Provider. Benefits are available for fitting, repairs, and replacement.

Reconstructive Services

The Plan provides benefits for certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process.

Covered Services include the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn Child;
- Breast reconstruction resulting from a mastectomy;
- Hemangiomas, and port wine stains of the head and neck areas for Children ages 18 years or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;

- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip; and
- Cleft palate.

Rehabilitation Services

The following Rehabilitation Services are covered on an Outpatient and Inpatient basis to help a person get back or improve skills and functioning for daily living that have been lost or impaired due to illness, injury, or disability:

- Physical therapy provided by a Physician or licensed physical therapist;
- Occupational therapy provided by a Physician or licensed occupational therapist;
- Speech therapy provided by a Physician or licensed speech therapist;
- Cardiac Rehabilitation Services provided under the supervision of a Physician or an appropriate Provider trained for cardiac rehabilitation; and
- Pulmonary Rehabilitation Services provided under the supervision of a Physician or an appropriate Provider trained for pulmonary rehabilitation.

All Therapy Services must be considered Medically Necessary. Prior Authorization is required for Outpatient physical, speech and occupational therapy.

When provided in a Facility on an Outpatient basis or in a Physician's office, You will be responsible for the Outpatient Rehabilitation Cost Share listed on Your Schedule of Benefits for each visit. When provided to You as an Inpatient, You will be responsible for the applicable Inpatient Cost Share listed on Your Schedule of Benefits.

Devices that are Medically Necessary to help a person get back or improve skills and functioning for daily living that have been lost or impaired due to illness, Injury, or disability are covered under the Durable Medical Equipment, prosthetics, or orthotics benefit, as applicable.

Benefits are limited to the maximum number of visits listed on Your Schedule of Benefits. For the purposes of this benefit, the term “visit” means any Outpatient visit to a Physician or Facility during which one or more of the therapies listed above are provided. The Outpatient Rehabilitation Services benefit limits described on Your Schedule of Benefits do not apply to Therapy Services provided for the treatment of a Mental Health Condition, including Autism Spectrum Disorder, or for the treatment of Substance Use. These limits also do not apply to Inpatient Rehabilitation Services or Rehabilitation Services provided as part of home health or Hospice Care.

Other Therapy Services

The Plan will provide benefits for Therapy Services for:

- **Cardiac rehabilitation** – to restore Your functional status after a cardiac event. Cardiac Rehabilitation Services includes a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Pulmonary rehabilitation** – to restore an individual's functional status after a sickness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling.
- **Chemotherapy** – for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis** – treatments of an Acute or chronic kidney ailment which may include the supportive

use of an artificial kidney machine.

- **Radiation therapy** – for the treatment of disease by X-ray, radium, or radioactive isotopes. Radiation therapy includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon, or high energy particle sources); materials and supplies used in therapy; and treatment planning.
- **Inhalation Therapy** – for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics of inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Post-Cochlear Implant Aural Therapy**
- **Cognitive Rehabilitation Therapy**

Surgical Services

The Plan provides benefits for surgical services when provided as part of Provider home visits and office services, Inpatient stays, or Outpatient Services. Surgical Services will only be Covered Services when provided in an appropriate setting, as determined by Us. Such benefits include but are not limited to:

- Performance of accepted operative and other invasive procedures, including but not limited to:
  - Operative and cutting procedures;
  - Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
  - Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
  - The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary (including when provided by a registered nurse first assistant, certified surgical assistant, or physician assistant);
- Usual and related pre-operative and post-operative care; or
- Other procedures as approved by us. We may combine the benefits when more than one surgery is performed during the same operative session.

Temporomandibular (TMJ) or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

We cover benefits for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders due to:

- An accident;
- Trauma;
- A congenital defect; or
- A pathology.

We will also cover orthognathic (jawbone) surgery for a medical condition or injury that is Medically Necessary to gain functional capacity of the joint or bone.

Transplant

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

Covered Services for human organ and stem cell/bone marrow transplants and transfusions are covered as Inpatient services, Outpatient Services or Provider home visits and office services 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.

Live Donor Health Care Services

The Plan provides benefits for Medically Necessary health care services only for the procurement of an organ from a live donor, including complications from the donor procedure for up to six (6) weeks from the date of the procurement.

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

Transportation, Lodging and Food

The Plan will provide travel expenses in connection with a pre-approved organ/tissue transplant. Organ transplant travel benefits are not available for cornea transplants. Travel expenses are limited to $10,000. Travel expenses are available to You for expenses associated with Your evaluation, candidacy, transplant, or post-transplant care. Transportation to and from the treatment site will be reimbursed at 37.5 cents per mile if You are required to travel more than sixty (60) miles from Your residence to reach the Facility where Your transplant procedure will be performed. Charges for a rental car used during a period of care at the transplant facility is also covered. Your benefit includes assistance with Your food and travel expenses, including transportation to and from the Facility and lodging for you, as the patient, and one (1) companion. If You are receiving treatment as a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two (2) companions. You must submit itemized receipts for transportation and lodging expenses accompanied by a completed Direct Member Reimbursement Form when reimbursement is requested. The Direct Member Reimbursement Form is located on Our website at antidotehealth.com.

Non-covered Transportation, Lodging and Food expenses include all of the following:

- Alcohol/tobacco;
- Vehicle Maintenance;
- Parking;
- Speeding Tickets;
- Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.);
- Expenses for persons other than You and Your authorized companion;
- Expenses for lodging when You stay with a relative;
- Any expenses not supported by a receipt;
- Personal care items (e.g., shampoo, deodorant, etc.);
- Telephone calls; and
- All other items not described in this Plan as eligible expenses.

Free-standing Urgent Care

The Plan provides benefits for Covered Services received at a free-standing urgent care center. A free-standing urgent care center is a licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Benefits are also available for Urgent Care services received at a non-Network Urgent Care Center while You are temporarily outside the Service Area. Benefits provided under this section are payable at the Network level and are limited to the Maximum Allowable Amount. Your payment is subject to any Coinsurance, Copayment, or Deductible. You may be responsible for any amount in excess of the Maximum Allowable Amount.

Urgent Care includes Medically Necessary services by Network Providers and services provided at a free-standing urgent care center, including Facility costs and supplies, or care for a condition that is not an emergency and does not require treatment in an emergency room, but is an unforeseen medical illness, injury, or condition that requires immediate care when the Covered Person's Primary Care Physician is unavailable or inaccessible. Certain Urgent Care services are available 24/7 by contacting Antidote at 888-623-3195 or antidotehealth.com.

Urgent Care received at any Hospital emergency department is not covered unless authorized in advance by us. Covered Persons are encouraged to contact their Primary Care Physician for an appointment before seeking care from another Provider, but free-standing urgent care centers and walk-in clinics can be used when an urgent appointment is not available. Urgent Care is not covered for services received by an Out-of-Network Provider or at an Out-of-Network Facility.

Prescription Drugs

Formulary Drugs

The Formulary is a list of Drugs We typically cover. We maintain a list of medications, typically a portion of those approved by the FDA, that We will cover. This list, referred to as the Antidote Formulary, is reviewed and updated by Us on a regular cycle. Our Pharmaceutical and Therapeutics Committee oversees the review process to ensure clinical, quality and cost considerations are appropriately evaluated. The Antidote Formulary includes medications in all classes of medications but does not necessarily include all forms of a given Prescription Drug (e.g., oral tablets, liquids, topical, etc.).

In addition to other amounts You owe (i.e., Copayment, Deductible, Coinsurance), You will be required to pay the difference in the medication cost of a Generic Drug medication versus a Brand Name Drug medication when You request the Brand Name Drug, and the prescribing Provider has indicated the Generic Drug equivalent substitution is clinically indicated.

Prescription Drugs that are approved under a Formulary exception request are considered eligible expenses under Your Plan. In the event a Formulary exception request is granted, any Copayment You owe will accumulate towards the Plan's annual limitation on Cost-Sharing, including the Plan's maximum Out-of-Pocket.

We update the Antidote Formulary on an ongoing basis, When We modify the Antidote Formulary we ensure it is effective uniformly among all individuals in a given Plan type and in accordance with federal and state law. When changes are made, We will notify both You and the Insurance Commissioner in accordance with the notice requirements in federal and state specific law. If it is determined that You are affected by a negative change in the Antidote Formulary, You will be notified sixty (60) days in advance of the change.

To facilitate appropriate benefit use and prevent opioid overutilization, Covered Person's

participation in lock-in status will be determined by review of Pharmacy claims. The lock-in program is sensitive to medical needs and does not solely consider quantitative factors (e.g., number of controlled substance prescriptions filled in a four-week span). Lock-in status helps prevent opioid abuse by requiring patients to seek opioids from a designated Provider and single Pharmacy for coverage. Your opioid prescription will not be covered if You attempt to fill the prescription from a Pharmacy other than Your designated Pharmacy.

To receive coverage for an Antidote Formulary medication, You must have a Health Care Provider prescribe You the medication and the medication must be determined by Our pharmacy benefits manager, Navitus Health Solutions to be Medically Necessary, (see Section: HOW YOUR PLAN WORKS). To request coverage for a medication not listed on the Antidote Formulary, You or Your Health Care Provider can submit a Formulary exception request.

If You have a question regarding whether a Drug is on the Formulary, please visit Our website at antidotehealth.com or call Us at the toll-free number on Your ID Card. Please see Your Right to Request an Exclusion Exception section below for additional details.

Prior Authorization

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

Prior Authorization for Covered Persons with Chronic Conditions

For Prior Authorization related to a Covered Person's chronic condition, We will honor the Prior Authorization for an approved Prescription Drug for twelve (12) months or until the last day of the Covered Person's eligibility under the Plan, whichever is less.

NOTE: The duration of all other Prior Authorization approvals will be governed by the Plan and this Evidence of Coverage. The twelve (12) month approval provided by Us will no longer be valid and will automatically terminate if there are changes to federal or state laws or federal regulatory guidance or compliance information prescribing that the Prescription Drug in question is no longer approved or safe for the intended purpose. We may require a Covered Person's Provider to submit information to Us indicating that a Covered Person's chronic condition has not changed. The frequency of the submission of requested information by the Plan will be consistent with medical or scientific evidence as required by law but will not be required more frequently than on a quarterly basis.

Tiers of Covered Drugs and Your Cost Share

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

- **Tier 1:** Generic Drugs.
- **Tier 2:** Preferred Brand Drugs.
- **Tier 3:** Non-Preferred Brand Drugs.
- **Tier 4:** Specialty Drugs.

Specialty Drugs

Drugs that require specialized patient education prior to use and ongoing patient assistance while under treatment are called Specialty Drugs. These Specialty Drugs must be dispensed through a Specialty Pharmacy. Please visit Our website at antidotehealth.com or call Member Services at the toll-free number on Your ID Card to find out if Your medication is considered a Specialty Drug and/or identify the best Specialty Pharmacy option for you.

How to Fill a Prescription

Prescriptions can be filled at a Network retail Pharmacy or through Our mail-order Pharmacy. If You decide to have Your prescription filled at a Network Pharmacy, You can use the Provider directory to find a Pharmacy near you. You can access the Provider directory at antidotehealth.com. You can also call Member Services to help You find a Pharmacy. At the Pharmacy, You will need to provide the pharmacist with Your prescription and Your ID Card. We also offer a three-month (90-day) supply of maintenance medications by mail through Costco Prescription Mail Order Service or from Network retail Pharmacies for specific benefit Plans. There is no requirement to be a member of Costco. These Drugs treat long-term conditions or illnesses, such as high blood pressure, asthma, and diabetes. You can find a list of covered medications on antidotehealth.com.

Mail Order Program

Mail order Pharmacies are an alternative way You can get Your medications. Certain eligible Covered Drugs, such as maintenance medications can be delivered to Your home. Not all Medications listed on the Formulary can be filled by mail order. You can find more information and the Formulary by going to antidotehealth.com. If You have any questions or need assistance in determining the amount of Your payment, or need to obtain the mail-order prescription form, You may contact Member Services at the toll-free number on Your ID Card.

Therapeutic Substitution of Drugs Program

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

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

Step Therapy

Step therapy protocol means that You may need to use one type of medication before another. If Your Provider decides that a step therapy medication is needed, Your Provider may request an exemption. We will review and respond to Your Provider's request for an exemption within forty-eight (48) hours for urgent requests, and within ten (10) calendar days for all other requests. If the exemption is granted, You will be able to obtain the requested medication without needing to proceed through the step therapy protocol.

NOTE: If We deny Your Provider's request for an exemption, You and Your Provider may appeal the decision. We will respond to appeals within one (1) business day for expedited appeals, and within ten (10) calendar days for all other appeals. If We deny the appeal, You or Your Authorized Representative may request an External Review. Please see Section XIII – APPEALS AND COMPLAINT PROCEDURES and the separate AZ Health Care Insurer Appeals

Process Information Packet that accompanied Your EOC.

Opioid Analgesics Prescribed for Chronic Pain

Covered Persons prescribed opioid analgesics for chronic pain must obtain Our Prior Authorization prior to receiving opioid analgesics for chronic pain, except under the following circumstances:

- Opioid analgesics prescribed to a Covered Person who is a Hospice patient in a Hospice Care program;
- Opioid analgesics prescribed to a Covered Person who has been diagnosed with a terminal condition, but is not a Hospice patient in a Hospice Care program; or
- Opioid analgesics prescribed to a Covered Person who has cancer or another condition associated with the Covered Person's cancer or history of cancer.

Covered Persons prescribed opioid analgesics for Acute and/or chronic pain may be subject to other Utilization Review measures as determined by Us, including care coordination for individuals with Substance Use. Prior Authorization requests for opioid treatment will be processed as an expedited request, and We will respond within forty-eight (48) hours. If Your request requires immediate action and a delay could significantly increase the risk to Your health, or the ability to regain maximum function, call Us as soon as possible. We will provide a written or electronic determination within twenty-four (24) hours. For more information on Opioid Education options, please visit Our website at antidotehealth.com.

Orally Administered Chemotherapy

Benefits for patient-administered cancer treatment medications will not be less favorable than the benefits for cancer treatment medications that are injected or intravenously administered by a health care Provider, regardless of the formulation or benefit category.

Your Right to Request a Formulary Exception

When a Prescription Drug product is excluded from coverage, You or Your licensed healthcare Provider may request an exception to gain access to the excluded Prescription Drug product. A Formulary exception request applies when Your Provider requests continued use of a non-Formulary Drug due to Medical Necessity, such as:

- Positive therapeutic outcomes with the current Drug
- Risk of adverse interactions with alternatives
- Lack of medical appropriateness of Formulary options

A Formulary Exception Request Form is available from Navitus Health Solutions, Our prescription benefits manager (PBM). The Provider who has prescribed the non-Formulary medication may obtain a copy of this form by calling a Pharmacy Support Representative toll free at 888-836-5146 or TTY 711 24 hours a day/7 days a week/365 days a year. The form is also available at antidotehealth.com/forms.

For standard exception requests, Navitus will notify You and Your Provider of Our determination within seventy-two (72) hours of receiving the Formulary exception request and clinical documentation. A standard exception request provides coverage of the non-Formulary Drug for the duration of the then current Benefit Period, but no more than 12 months, including the duration of prescription and refills.

Urgent Formulary Exception Requests

If Your exception request is exigent (urgent) and requires immediate action such that a delay could significantly increase the risk to Your health, or the ability to regain maximum function, have Your

Provider call Navitus as soon as possible. Navitus will provide You and Your Provider with a written or electronic determination within twenty-four (24) hours of receiving the Formulary exception request and clinical documentation. An exception request based on exigent circumstances provides coverage of the non-Formulary Drug for the shorter of the duration of the exigency, duration of the then current Benefit Period, or 12 months.

Approval/Denial of Formulary Exception Requests

Please note, if Your Provider's request for an exception is approved by Us, You may be responsible for paying the applicable Copayment and/or Coinsurance based on the Prescription Drug tier placement, or at the highest tier.

You and Your Provider will receive written notification of the approval. If You renew the same Plan the following year, a new exception request is required.

If Your exception request is denied, You and Your Provider will receive written notification, medical or pharmacological rationale for the denial and details on Your appeal options.

Standard External Review

If You are not satisfied with Our determination of Your Formulary exception request, You may request an external review. You, Your Authorized Representative or Your Provider may request an external review by sending a written request to Us to the address set out in the determination letter or by calling the toll-free number on Your ID Card. The assigned IRO will deliver a notice of the final external review decision in writing to You and Your Provider within seventy-two (72) hours of the IRO's receipt of the request for a standard external review request and clinical documentation.

Expedited External Review

If You are not satisfied with Our determination of Your Formulary exception request and it involves an urgent situation, You, Your Authorized Representative or Your Provider may request an expedited external review by calling the toll-free number on Your ID Card or by sending a written request to the address set out in the determination letter. The IRO will notify You and Your Provider of Our determination within twenty-four (24) hours. Please refer to Your Appeals Packet for additional information regarding expedited appeals for urgently needed services you have not yet received.

Negative Formulary Changes

Negative Formulary changes include, but are not limited to:

- A Drug product or chemical entity being removed from the Formulary.
- A Drug being moved to a higher tier.
- The addition of or more aggressive use of utilization criteria such as Prior Authorization, Step Therapy, or Quantity Limits.

Negative Formulary changes and alternatives are approved by the Pharmacy and Therapeutics Committee prior to implementation with the following exceptions:

- Branded medications that have A-rated equivalent generics or an equivalent chemical entity available at an equal or lower tier.
- Products that have been recalled by the FDA.

If a Negative Formulary change removes or restricts coverage of a Drug, Navitus notifies You at least 60 days in advance of the effective date of the change.

Off-Label Use

You may be eligible for coverage for a Prescription Drug that has not been approved by the Food and Drug Administration (FDA) for treatment of the specific type of cancer for which the Prescription Drug has been prescribed, if the Prescription Drug has been recognized as safe and effective for treatment of that specific type of cancer in one or more of the standard medical reference compendia set forth below or if there is medical literature that meets the following criteria:

Standard Medical Compendium

1. The American Hospital Formulary Service Drug Information, a publication of the American Society of Health-System Pharmacists.
2. The National Comprehensive Cancer Network Drugs & Biologics Compendium (NCCN Compendium®).
3. Thomson Micromedex DrugDex® Compendium.
4. Elsevier Gold Standard's Drug Database clinical pharmacology compendium.
5. Other authoritative compendia as identified by the Secretary of the U.S. Department of Health and Human Services.

Medical Literature Criteria

Medical literature may be accepted if **all** the following apply:

1. At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the Drug's safety and effectiveness for treatment of the indication for which the Drug has been prescribed.
2. No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the Drug is unsafe or ineffective or that the Drug's safety and effectiveness cannot be determined for the treatment of the indication for which the Drug has been prescribed.
3. The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or is published in a journal specified by the U.S. Department of Health & Human Services as acceptable peer-reviewed medical literature.

You or the Provider who has prescribed the medication may obtain more information by calling a Pharmacy Support Representative toll free at 888-836-5146 or TTY 711 24/7/365.

Medically Necessary services associated with the administration of the Prescription Drug for off-label use is covered under this Plan.

Medication Synchronization

If You are filling more than two prescribed medications for a chronic condition that are being dispensed by a single Pharmacy, You have the option to coordinate the refilling of Your medications to a single Pharmacy visit. This will allow the Copayments to be prorated based on the synchronized days' supply.

Please call the number on the back of Your ID Card for more information on this program.

Prescription Drug Exclusions and Limitations

No benefits will be paid under this benefit subsection for services provided or expenses incurred:

- For Prescription Drugs for the treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the Formulary.

- For weight loss Prescription Drugs unless otherwise listed on the Formulary.
- For immunization agents, blood, or blood plasma, except when used for preventive care and listed on the Formulary.
- For medication that is to be taken by the Covered Person, in whole or in part, at the place where it is dispensed.
- For medication received while the Covered Person is a patient at an institution that has a Facility for dispensing pharmaceuticals.
- For a refill dispensed more than twelve (12) months from the date of a Provider's order.
- For more than the predetermined managed Drug limitations assigned to certain Drugs or classification of Drugs.
- For a Prescription Order that is available in over-the-counter form or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are on the Formulary.
- For Drugs labeled "Caution - limited by federal law to investigational use" or for Investigational or Experimental Drugs.
- For any Drug that We identify as therapeutic duplication through the Drug Utilization Review program. Therapeutic duplication is the practice of prescribing multiple medications for the same indication or purpose without a clear distinction of when one agent should be administered over another.
- For more than a 30-day supply when dispensed in any one prescription or refill, or for maintenance Drugs, up to 90-day supply when dispensed by mail order or a Pharmacy that participates in extended day supply network.
    - Specialty Drugs and other select Drug categories are limited to 30-day supply when dispensed by retail or mail order. Please note that only the 90-day supply is subject to the discounted Cost-Sharing. Mail orders supplies of fewer than 90 days are subject to the standard Cost-Sharing amount.
- For Prescription Drugs for any Covered Person who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription Drug coverage may not be reinstated at a later date.
- Foreign prescription medications, except those associated with an Emergency Medical Condition while You are travelling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this document, if obtained in the United States.
- For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to Covered Person’s vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
- For medications used for cosmetic purposes, excluding Tretinoin.
- For infertility Drugs unless otherwise listed on the Formulary.
- For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
- For Drugs or dosage amounts determined by Us to be ineffective, unproven, or unsafe for the indication for which they have been prescribed, regardless of whether such Drugs or dosage amounts have been approved by any governmental regulatory body for that use.
- For any Drug related to dental restorative treatment or treatment of chronic periodontitis, where Drug administration occurs at dental practitioner’s office.
- For any Drug related to surrogate pregnancy for a non-Covered Person.
- For any Drug used to treat hyperhidrosis.
- For any prescription or over the counter version of vitamin(s) unless otherwise included on the Formulary.

- For any claim submitted by non lock-in Pharmacy while a Covered Person is in lock-in status.
    - Lock-in status means You are locked-in to a specific Pharmacy in order to monitor prescription in order to monitor prescriptions received.
    - Lock-in Pharmacy means Your designated Pharmacy for coverage.
    - Lock-in status helps prevent opioid abuse by requiring patients to seek opioids from a designated Provider and single Pharmacy for coverage. Your opioid prescription will not be covered if You attempt to fill the prescription from a Pharmacy other than Your designated Pharmacy.
    - To facilitate appropriate benefit use and prevent opioid overutilization, Covered Person's participation in lock-in status will be determined by review of Pharmacy claims.
- Compound Drugs unless there is at least one ingredient that requires a prescription.

SECTION VI – EXCLUSIONS AND LIMITATIONS

No benefits will be provided or paid for:

- Any service or supply that would be provided without cost to the Covered Person in the absence of insurance covering the charge.
- Expenses, fees, taxes or surcharges imposed on the Covered Person by a Provider (including a Hospital) but that are actually the responsibility of the Provider to pay.
- Any services not identified and included as Covered Service expenses under the contract. You will be fully responsible for payment for any services that are not Covered Service expenses.

Even if not specifically excluded by this contract, no benefit will be paid for a service or supply unless it is:

- Administered or ordered by a Provider; and
- Medically Necessary to the diagnosis or treatment of an injury or illness or covered under the Preventive Care provision.

Covered Service expenses will not include, and no benefits will be provided or paid for any charges that are incurred:

- For services or supplies that are provided prior to the Effective Date or after the termination date of this contract, except as expressly provided for under the contract's TERMINATION section.
- For any portion of the charges that are in excess of the eligible service expense.
- For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery, except the Medically Necessary bariatric procedures identified as Covered Services.
- For cosmetic breast reduction or augmentation.
- For the reversal of sterilization and vasectomies.
- For gender affirming care.
- For non-therapeutic abortion.
- For expenses for television, telephone, or expenses for other persons.
- For telephone consultations, except those meeting the definition of Telehealth services, or for failure to keep a scheduled appointment.
- For cosmetic treatment, except for Medically Necessary reconstructive surgery that is incidental to or follows surgery or an injury or is performed to correct a birth defect.
- For diagnosis or treatment of learning disabilities.
- For diagnosis or treatment of nicotine addiction, except as expressly provided for under Preventive Care Services.
- For eye refractive surgery when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
- While confined primarily to receive rehabilitation, Custodial Care, educational care, or nursing services (unless expressly provided for in this contract).
- For vocational or recreational therapy, vocational rehabilitation, Outpatient speech therapy, or occupational therapy, except as expressly provided for in this contract.
- For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.

- For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this contract.
- Except as otherwise explicitly stated in this Policy (including under the Clinical Trials' and Prescription Drug' benefit sections) or as required by applicable state or federal law, the Plan excludes coverage for Experimental or Investigative treatment(s) or unproven services. The fact that an Experimental or Investigative treatment or unproven service is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an Experimental or Investigative treatment or unproven service for the treatment of that particular condition. These services may be related to medical, surgical, diagnostic, psychiatric, Substance Use or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan to be:
    - Not approved by the FDA to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
    - The subject of review or approval by an 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 as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight (except as set forth in the Cancer Clinical Trials provision of this Plan under Covered Services and Supplies; or
    - Not demonstrated, through existing peer reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
- For treatment received outside the United States, except for Emergency Services while traveling for up to a maximum of ninety (90) consecutive days.
- As a result of an injury, disease, defect, or ailment arising out of and in the course of employment for wage or profit, if the Covered Person is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If workers' compensation insurance is not available to You, then this Exclusion does not apply. This Exclusion applies if You receive the benefits in whole or in part. This Exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party. If You enter into a settlement that waives a Covered Person's right to recover future medical benefits under a workers' compensation law or insurance plan, this Exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a Covered Person's workers' compensation claim, this Exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
  The following health care services, including supplies and medication to a non-Covered Person serving as a surrogate/gestational carrier pursuant to a surrogacy/gestational carrier arrangement with a Covered Person are excluded. This Exclusion applies to all health care services, supplies and medication to the non-covered surrogate/gestational carrier including:
    - Intrapartum care (or care provided during delivery and childbirth);
    - Postpartum care (or care for the surrogate/gestational carrier following childbirth);
    - Mental health services related to the surrogacy/gestational carrier arrangement;

- Expenses relating to donor semen, including collection and preparation for implantation;
- Donor gamete or embryos or storage relating to a surrogacy/gestational carrier arrangement;
- Use of frozen gamete or embryos to achieve future conception in a surrogacy/gestational carrier arrangement;
- Preimplantation genetic diagnoses relating to a surrogacy/gestational carrier arrangement.
- Any complications of the surrogate/gestational carrier resulting from the pregnancy; or
- Any other health care services, supplies and medication relating to the surrogacy/gestational carrier arrangement.

Please also see Adding New Dependents and Who Can Be Covered sections.

- For or related to treatment of hyperhidrosis (excessive sweating).
- For fetal reduction surgery.
- Except as specifically identified as a Covered Service expense under the contract, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- For any injectable medication or biological product that is not expected to be self-administered by the Covered Person at the Covered Person's place of residence unless listed on the Formulary.
- Services related to the terminal illness that are obtained outside of or are not arranged through the hospice program are not covered unless otherwise required by law or expressly authorized by Us.
- Domiciliary 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.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, except benefits for Mental Health Conditions or Substance Use. Benefits are provided for a minor solely for Medically Necessary mental health or Substance Use services provided in a school or other educational setting or ordered by a court if the service was provided by an In-Network Provider. Claims for mental health or Substance Use services that are provided by an Out-of-Network Provider and are not covered by Us solely because the Provider is an Out-of-Network Provider may be payable from the Arizona Children's Behavioral Health Services Fund. Further information on the availability of mental health and Substance Use services for a minor are available at https://www.azahcccs.gov/AHCCCS/Initiatives/BehavioralHealthServices/.
- The following bariatric procedures:
  - Open vertical banded gastroplasty;
  - Laparoscopic vertical banded gastroplasty;
  - Open sleeve gastrectomy;
  - Open adjustable gastric banding.
- For Diagnostic testing, laboratory procedures, screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment. This Exclusion does not apply to preventive services.
- Surgical treatment of gynecomastia

- For any medicinal and recreational use of cannabis or marijuana.
- Dental services unless specifically listed under Covered Services.

SECTION VII – WELLNESS AND REWARDS PROGRAM

It takes commitment and dedication to get healthy and stay healthy. Eating and sleeping well, staying active, engaging with Your Primary Care Provider to set health goals, and getting an annual checkup are just some of the ways You can start Your journey to better health.

This Plan offers wellness and health improvement programs to encourage You to complete health activities that support overall health. You may be offered incentives to encourage You to participate in certain wellness or disease management programs. The decision about whether to participate is Yours. These incentives are not benefits and do not alter or affect Your benefits.

For more information, log into Your online app or call Member Services at 888-623-3195.

SECTION VIII – WHO GETS BENEFITS

You must complete an enrollment form given to You by the Group. The Group will submit the completed forms to Us, along with any required Premium. We will not provide benefits for health care services that You receive before Your Effective Date of coverage. You and Your Dependents must live, work, or reside in Our Service Area to be covered under this Plan. Your Dependents may also be covered depending on the type of coverage You select.

Open Enrollment Period

The open enrollment period is the period of time when eligible persons can enroll themselves and their Dependents, as determined by Us. Coverage begins on the date determined by the Group and identified in this Plan if We receive the completed enrollment materials and the required Premium from the Group.

Special Enrollment Period

An eligible person and/or Dependent may also be able to enroll during a special enrollment period, as determined by Us and in accordance with federal and state law.

A qualified individual has sixty (60) days to report a qualifying event directly to the Group and could be granted a 60-day Special Enrollment Period as a result of one of the following qualifying life events:

- Change or loss of employment;
- Losing existing health coverage, including Medicaid;
- Moving to a new ZIP code or county;
- Having a baby or adopting a Child; or
- Becoming divorced or separated.

Any circumstances that cause You to lose or experience a change in health insurance may make You eligible for a Special Enrollment Period due to a qualifying life event.

Adding New Dependents

Enrollees may enroll Dependents only as determined by federal and state law.

The enrollee must notify the Group of a new Dependent to be added to this Group Policy and complete the enrollment form. The Effective Date of the Dependent's coverage must follow federal and state laws.

Who Can Be Covered

- The enrollee – You, if You are an eligible person.
- Your Spouse, under an existing marriage legally recognized under the laws of the state of Arizona.
- Your domestic partner under the terms and conditions of this Evidence of Coverage is eligible for enrollment.
- Your Child (married or unmarried) who has not yet attained the age of 26 is eligible for enrollment. Children covered under this Plan include:
    - Your natural Children;
    - Legally adopted Children;
    - Stepchildren;
    - Children awarded coverage pursuant to an order of the court;
    - Foster Children who are placed by an authorized placement agency or by judgment,

decree, or other order of any court of competent jurisdiction;

- An adopted Child, including a Child who is placed with You for adoption, is automatically covered for thirty-one (31) days from the date of the adopted Child's Placement for Adoption or initiation of a suit of adoption and upon notification to the Group and Antidote. To continue coverage past that time You must enroll the Child as an Insured family member by applying for his or her enrollment as a Dependent within sixty (60) days of the date of adoption and the Group must pay any additional Premium. Coverage for an adopted Dependent Child enrolled within sixty (60) days of adoption will be retroactive to the date of the Child's Placement for Adoption or initiation of a suit of adoption; and
- Your own, or Your Spouse's newborn Children are automatically covered for the first thirty-one (31) days of life and upon notification to Group and Antidote. To continue coverage past that time You must enroll the Child as an insured family member by applying for his or her enrollment as a Dependent within sixty (60) days of the date of birth and the Group must pay any additional Premium. We will allow You an additional ten (10) days from the date the forms and instructions are provided in which to enroll the newly born Child. Coverage for a newborn Dependent Child enrolled within sixty (60) days of birth will be retroactive to the date of the Child's birth.
- Coverage is provided for a Child born through a surrogate agreement only if the Child is the legal Child of You or Your Spouse under this Plan. In such cases, the Child will be covered for the first thirty-one (31) days of life upon notification to Us. To continue coverage past that time, You must enroll the Child as an insured family member by applying for their enrollment as a Dependent within sixty (60) days of the date of birth and pay any additional Premium. If You serve as a surrogate for another individual or couple, any child born as a result of that surrogacy arrangement will not be considered a dependent of You and will not be eligible for coverage under this Plan.

Coverage lasts until the end of the calendar year in which the Child turns 26 years of age.

Coverage for a Disabled Dependent Child

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

- The Dependent Child is not able to support him/herself because of mental, developmental, or physical disability; and
- The Dependent Child depends mainly on the enrollee for support. Coverage will continue as long as the Dependent Child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of this Group Policy.

You must furnish Us with proof of the medical certification of disability within thirty-one (31) days of the date coverage would have ended because the Child reached age 26. Before We agree to this extension of coverage for the Child, We may require that a Physician We choose examine the Child. We will pay for that exam.

We may continue to ask You for proof that the Child continues to be disabled and Dependent. Such proof might include medical exams at Our expense. We will not ask for this information more than once a year. If You do not provide proof of the Child's disability and dependency within thirty-one (31) days of Our request as described above, coverage for that Child will end.

Specific Causes for Ineligibility

Unless described differently in the "Continuation" section, a Covered Person will become ineligible for coverage under the Plan for the following reasons:

- If Premiums are not paid according to the due dates and grace periods as described in the HOW YOUR PLAN WORKS section;
- If a Spouse is no longer married to the Covered Person;
- For You and Your Dependents – when You or Your Dependents no longer meet the requirements listed in the WHO GETS BENEFITS section;
- The date the Plan terminates; or
- When a Covered Person no longer lives in the Enrollment area.

It is Your responsibility to notify Us immediately if any changes occur which may affect You or any of Your Dependents' eligibility for benefits under this Plan.

Active-Duty Military Service

We do not cover conditions which occur while a Covered Person is participating in military service. If You become an active-duty member of any branch of military service, You must notify Us. After receiving this notification, We will issue a pro-rata refund of unearned Premium.

Domestic Partner Coverage

This Plan covers a domestic partner of the enrollee the same as a Spouse. If You selected family coverage, Children covered under this Plan also include the Children of 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.

SECTION IX – TERMINATION

The term of this Evidence of Coverage commences on the Evidence of Coverage Effective Date and continues through the Benefit Period.

As permitted by law, We may end this Evidence of Coverage and/or all similar policies for the reasons explained in this Evidence of Coverage.

Your right to benefits automatically ends on the date that coverage ends, even if You are hospitalized or are otherwise receiving medical treatment on that date.

When Your coverage ends, We will still pay claims for Covered Services for health care that You received before the date Your coverage ended. However, once Your coverage ends, We will not pay claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date Your coverage ended).

Unless otherwise stated, an enrolled Dependent's coverage ends on the date the enrollee's coverage ends. We will refund to Group any Premium paid and not earned due to Group Policy termination.

What Events End Your Coverage?

- **The Entire Group Policy Ends**
  - Your coverage ends on the date this Group Policy ends. That date will be one of the following:
    - The date determined by the Antidote or Group that Your coverage will terminate because You no longer live in the Service Area;
    - The date We specify, after We give You ninety (90) days prior written notice, that We will terminate this Group Policy because We will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where You reside; or
    - The date We specify, after We give You and the applicable state authority at least one hundred eighty (180) days prior written notice, that We will terminate this Group Policy because We will discontinue offering and refuse to renew all Group policies in the market in the state where You reside.
- **You Are No Longer Eligible**
  - Your coverage ends on the date You are no longer eligible to be an enrollee or an enrolled Dependent, as determined by the Group. Please refer to Section II – DEFINITIONS for definitions of the terms “Covered Person” and " Dependent."
- **We Receive Notice to End Coverage**
  - Your coverage ends on the date determined by the Group if We receive notice from the Group instructing Us to end Your coverage.

Other Events Ending Your Coverage

When any of the following happen, We will provide written notice to the Group that coverage has ended on the date We identify in the notice.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  We will provide at least thirty (30) days advance required notice to the Group that coverage will end on the date We identify in the notice because You committed an act,

practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision. If We find that You have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, We have the right to demand that You pay back all benefits We paid to You, or paid in Your name, during the time You were incorrectly covered under the Group Policy.

- **You Accept Reimbursement for Premium**

  You accept any direct or indirect contribution or reimbursement by or on behalf of any third party including, but not limited to, any Health Care Provider or any Health Care Provider sponsored organization for any portion of the Premium for coverage under this Group Policy. This prohibition does not apply to the following third parties:
  - Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
  - Indian tribes, tribal organizations or urban Indian organizations.
  - Local, state and federal government programs, including grantees directed by government programs to make payments on their behalf consistent with the program's statutory authority.

Health Status

Covered Persons enrolled under this Evidence of Coverage will not have coverage terminated because of health status, or the need for Medically Necessary Covered Services.

Continuation

Covered Dependents have the right to continuation of Your insurance if their eligibility under this Plan would terminate due to:
- Your death,
- Voluntary or involuntary termination of employment for a reason other than gross misconduct or reduction of hours required to qualify for health benefits under the Group's health benefits Plan,
- Divorce, and
- Age.

Coverage will continue provided that the Covered Person exercising the continuation right notifies the Group and pays the appropriate monthly Premium within sixty (60) days following the date this Plan would otherwise terminate. If this is the case, coverage will continue without evidence of insurability. Please see the Special Enrollment Period section under the WHO GETS BENEFITS section for further detail.

Termination of Group for Non-Payment of Premium

- Any Group that does not pay its monthly Premium in full by the 55th calendar day following the first day of the coverage month for which Premium payment was due, is subject to termination of its Group Policy.
- Coverage for all Group Members (enrollees and Dependents) will end on the 60th calendar day after the first day of the coverage month for which Premium payment was due and not paid in full.
- Termination is retroactive to the last day of the coverage month for which Premium was paid.

- Antidote will send written notice to the Group and each Group Member (at their last known address) about the Group's termination due to nonpayment of Premium. The notice will include the Effective Date of the termination of the Group Policy and information about Your continuation of coverage options.
- Unless You elect the continuation of coverage option and make the required Premium payment, You are responsible for all claims for services received after the Effective Date of termination (which can be up to 60 calendar days back to the date of termination).

SECTION X – COST-SHARING AND PAYMENT OBLIGATIONS

Eligible Expenses

We provide coverage for several categories of eligible expenses, including but not limited to:

- Inpatient Hospital Expenses;
- Medical-Surgical Expenses;
- Extended Care Expenses;
- Preventive Care Expenses; and
- Prescription Drug Expenses.

Your benefits are calculated on a Plan Year Benefit Period basis unless otherwise stated. At the end of a Plan Year, a new Benefit Period starts for each Covered Person.

Allowed Amount

The Allowed Amount is the maximum amount of benefits We will pay for Covered Services expenses You incur under Our Plan. We have established an Allowed Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with Us. You will be responsible for charges of services, supplies, and procedures limited or not covered under Our Plan, You will also be responsible for any applicable Deductibles, Coinsurance and Copayment amounts.

Review the definition of Allowed Amount in the DEFINITIONS section of this Plan to understand the guidelines used by Us.

Deductibles

Except where stated otherwise, You must pay the Deductible for Covered Services during each calendar year before we'll provide payment.

If You have something other than individual coverage, the individual Deductible applies to each person covered under this Plan. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year.

However, after Deductible payments for persons covered under this Plan collectively total the family Deductible amount in Your Schedule of Benefits in a Plan Year, no further Deductible will be required for any person covered under this Plan for that Plan Year.

The Deductible runs from January 1 to December 31 of each calendar year.

Copayment Amounts

Some of the care and treatment You receive under this Plan requires that a Copayment amount be paid at the time You receive services. Refer to Your Schedule of Benefits for Your specific Plan information. Your Schedule of Benefits will indicate the basis of which a Copayment amount is calculated. It may be per visit, per day, per service, or any combination thereof.

Coinsurance Amounts

Some of the care and treatment You receive under this Plan requires that a Coinsurance amount be paid at the time You receive the services. Refer to Your Schedule of Benefits for Your specific Coinsurance information.

Except where stated otherwise, after You have satisfied the Deductible described above, You are required to pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount of Your benefit as shown in Your Schedule of Benefits.

Maximum Out-of-Pocket

Most of Your Covered Services expense payment obligations, including Deductibles, Copayment amounts, and Coinsurance amounts, are applied to the maximum Out-of-Pocket.

Your maximum Out-of-Pocket amount will not include:

- Cost-Sharing for Out-of-Network services, except for Emergency Services and for ancillary services or Diagnostic Services that are provided at an In-Network Hospital, In-Network Hospital Outpatient department, or In-Network Ambulatory Surgical Center;
- Services, supplies, or charges limited or excluded by Us; and
- Expenses not covered because a Benefit Period Maximum has been reached.

Family Maximum Out-of-Pocket

The Covered Service expenses that cover Covered Persons in a family unit, except as described below, are counted towards both the individual and family maximum Out-of-Pocket amounts. The family maximum Out-of-Pocket is listed in the Schedule of Benefits and is two times the individual maximum Out-of-Pocket Amount.

When the individual maximum Out-of-Pocket is reached for an Individual in a Plan Year, Covered Service expenses for that individual, except as described below, are payable at 100% for the remainder of the Plan Year by Us, even if the family maximum Out-of-Pocket has not been reached.

When the family maximum Out-of-Pocket is reached for a family in a Year, Covered Service expenses for that family, except as described below, are payable at 100% for the remainder of the Plan Year by Us. The family Out-of-Pocket maximum amount can be met with the combination of any amounts paid towards one or more of Your individual Deductibles, Copayments, and Coinsurance. The following are not counted toward the individual or family maximum Out-of-Pocket and will not be paid at 100% once the maximum Out-of-Pocket is met. They will be subject to the Copayment, Coinsurance and/or Deductible as shown in the Schedule of Benefits:

Any percentage of Covered Service expenses that a Covered Person must pay due to failure to follow any requirements of Prior Authorization for Out-of-Network Providers.

Limitations and Exclusions. Refer to Your Schedule of Benefits for Coinsurance percentage and other limitations. The amount payable will be subject to:

- Any specific benefit limits stated in the contract;
- A determination of Covered Service expenses;
- Any reduction for expenses incurred at an Out-of-Network Provider. Please refer to the information on the Schedule of Benefits; and
- With the exception of Copayments, Coinsurance and Deductible amounts, You are not responsible for any additional expenses, fees, taxes or surcharges. If You have any questions about whether the amounts billed by a Provider are accurate, contact Member Services at 888-623-3195 and a representative will assist You.

In the event a Group is late (delinquent) in paying required premium, the Plan, in accordance with applicable state and federal law, may suspend payment of claims and/or Prior Authorization of services until full Premium payment is received.

Premium Payments from Third Parties

We only accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
- Indian tribes, tribal organizations, or urban Indian organizations; and
- Local, state, and federal government programs, including grantees directed by government programs to make payments on their behalf consistent with the program's statutory authority.

Note: Each Premium is to be paid by You, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any Health Care Provider or any Health Care Provider sponsored organization.

Adjustment of Premiums

The monthly Premiums shall be effective until notification of adjustment to Premiums is provided by the Group to You. We will notify the Group of any adjustment to Premiums, not less than sixty (60) days prior to the Effective Date of such rate change, or as permitted by law. Premium changes are subject to review and approval by the Arizona Department of Insurance and Financial Institutions.

Misrepresentation Regarding Tobacco Use

If a Covered Person makes an intentional misrepresentation of a material fact regarding the use of tobacco on the enrollment application and is later found to be using tobacco, the misrepresentation may result in You being charged the rate applicable if the tobacco use had been disclosed at the beginning of the Evidence of Coverage Enrollment Date. We reserve the right to retroactively bill the Group for the difference in Premium. We will not terminate Your coverage for misrepresentation of tobacco use.

SECTION XI – PRIOR AUTHORIZATION

Prior Authorization

Some services and items require Prior Authorization. Prior Authorization is the process used by Us to determine whether health care services listed on Our Prior Authorization Grid meet evidence-based criteria for Medical Necessity and coverage requirements and are Covered Services under Your Plan prior to the health care service being rendered. Emergency Services and emergency inpatient admissions do not require Prior Authorization for the initial medical screening examination and immediately necessary stabilizing treatment of an Emergency Medical Condition. Following stabilization, We may conduct a review to determine the Medical Necessity of continued services and may require Prior Authorization for post-stabilization care. We may also direct Your care, including arranging transfer to a Network Provider, provided the treating Provider determines You are stable for transfer and transfer requirements are met. Such post-stabilization review and care direction do not affect coverage of the initial Emergency Services and stabilizing treatment rendered prior to stabilization. It is the responsibility of Your Network Provider to obtain Prior Authorization from Us prior to providing a service or supply to a Covered Person. Please check with Your Network Provider to ensure that Your Network Provider has obtained Prior Authorization before You receive any health care services listed on the Prior Authorization Grid. The Prior Authorization Grid is available by calling Member Services at 888-623-3195 Monday through Friday 8:00 a.m. to 8:00 p.m. or by viewing it in the Member section on Our website at antidotehealth.com. Except for Emergency Services, services provided by an Out-of-Network Provider are considered non-Covered Services.

There are some Network eligible services expenses for which You must obtain Prior Authorization. Additional information regarding the services that require Prior Authorization is available at antidotehealth.com.

For services or supplies that require Prior Authorization, as shown on the Prior Authorization Grid, You must obtain Prior Authorization from Us before You or Your Dependent Covered Person:

- Receives a service or supply from an Out-of-Network Provider;
- Are admitted into a Network Facility by an Out-of-Network Provider; or
- Receive a service or supply from a Network Provider to which You or Your Dependent Covered Person were referred by an Out-of-Network Provider.

Prior Authorization (medical and behavioral health) requests must be received by phone/efax/Provider portal as follows:

- At least five (5) days prior to an elective or scheduled admission as an Inpatient in a Hospital, extended care or rehabilitation Facility, or Hospice Facility or as soon as reasonably possible.
- At least thirty (30) days prior to the initial evaluation for organ transplant services or as soon as reasonably possible.
- At least thirty (30) days prior to receiving clinical trial services or as soon as reasonably possible.
- For emergency inpatient admissions, Prior Authorization is not required. Following stabilization of the Emergency Medical Condition, the Hospital or Provider should notify Us as soon as reasonably possible, and preferably within twenty-four (24) hours of the admission, to allow concurrent review of continued inpatient care and coordination of post-stabilization services. Failure to provide this notification will not affect coverage of Emergency Services or emergency stabilization services.
- At least five (5) days prior to the start of home health care except for Covered Persons

needing home health care after Hospital discharge.

Reconsideration of Adverse Benefit Determination

For Adverse Benefit Determinations related to concurrent service requests or pre-service requests, Your Provider or Facility rendering the Covered Service may request, in writing on Your behalf, a reconsideration of the Adverse Benefit Determination. The Provider or Facility may not request reconsideration without Your prior written consent. See Section XIII – APPEALS AND COMPLAINT PROCEDURES.

SECTION XII – CLAIMS AND REIMBURSEMENT

Claims

Your In-Network Provider is responsible for requesting payment from Us.

If Your Provider is unable to submit claims for payment to Us in accordance with the Plan's customary practices, You may submit a claim directly to Us by using the claim form that can be found at [antidotehealth.com] or by calling Member Services.

When an In-Network Provider is not timely accessible or available, You may obtain a Network exception by calling Member Services.

Sometimes You may need to submit claims Yourself for Covered Services. This usually happens if:

- Your Provider is not contracted with Us; or
- You require Emergency Services, and You are outside the Service Area.

If You have paid for services We agreed to cover, You can request reimbursement for the amount You paid. We can adjust Your Deductible, Copayment or Cost-Sharing to reimburse You.

To request reimbursement for a Covered Service, You need a copy of the itemized bill or itemized statement from Your Provider. You also need to submit an explanation of why You paid for the Covered Services along with the Direct Member Reimbursement Form posted at antidotehealth.com . Send all the documentation to Us at the following address:

Antidote
Attn: Member Services, Antidote Health Plan
[PO Box 39638
Solon, OH 44139]

Reimbursement

Reimbursement will be made only for Covered Services received in accordance with the provisions of this Plan. In the event You are required to make payment other than a required Copayment, Deductible or Coinsurance amount at the time Covered Services are rendered, We will ask that Your Provider reimburse You, or We will reimburse You.

Explanation of Benefits

After You receive Covered Services, You will generally receive a written explanation of benefits summarizing the benefits You receive. This explanation of benefits is not a bill for health care services.

SECTION XIII – APPEALS AND COMPLAINT PROCEDURES

Call Member Services

Please contact Our Member Services team at the toll-free number on Your ID Card if You have questions about Your benefits or any concerns. We will attempt to resolve Your question or concern during initial contact.

At maximum, within thirty (30) calendar days of receipt, We will investigate, resolve, and respond to Your question or concern.

Grievance Procedure

Grievances are an expression of unhappiness or dissatisfaction relating to any aspect of Our operation. If You have a grievance, please contact Us. We will investigate, work to resolve, and respond to Your grievance within thirty (30) days of Our receipt of the grievance.

Appeals

Please refer to Your Appeals Packet for additional information. The Appeals Packet outlines the details regarding the Arizona Grievance and Appeals procedures. The appeals process is intended to solely address appeals of Final Adverse Benefit Determinations. This process is distinct from the Grievance Procedure described above. The Appeals Packet is available by calling the Member Services team at toll-free number on Your ID Card or visiting Our website at antidotehealth.com and is also located in Exhibit A.

SECTION XIV – GENERAL PROVISIONS

Assignment: You cannot assign any benefits under this Plan to any person, corporation, or other organization without obtaining written permission from the Plan. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Plan or Your right to collect money from Us for those services.

Changes in this Plan: 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.

Choice of Law: This Plan shall be governed by the laws of the state of Arizona.

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.

Conformity with State Laws: Any part of this contract in conflict with the laws of Arizona on this contract's Effective Date or on any Premium due date is changed to conform to the minimum requirements of Arizona state law.

Coverage Effective Date: Coverage takes effect on the Effective Date shown on the cover page. If the Group submits all required enrollment materials and pays the initial Premium between the 1st and the 15th of the month, the Effective Date of the Group Policy will be the 1st day of the following month. If the Group submits all required enrollment materials and pays the initial Premium on or after the 16th of the month, the Effective Date of the Group Policy will be the 1st day of the second following month. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by Us when due. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where You live.

Entire Contract: This contract, with the application, amendments, and Schedule of Benefits is the entire contract between You and Us. No agent may:

- Change this contract;
- Waive any of the provisions of this contract;
- Extend the time for payment of Premiums; or
- Waive any of Our rights or requirements.

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

Identification (ID) Cards: Identification (“ID”) cards are issued by Us for identification purposes only. Possession of any ID Card confers no right to services or benefits under this Group Policy. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

Rescission: No misrepresentation of facts made regarding a Covered Person during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

- The misrepresented fact is contained in a written application, including amendments, signed by a Covered Person;

- A copy of the application, and any amendments, has been furnished to the Covered Person(s), or to their beneficiary; and
- The misrepresentation of fact was intentionally made and material to Our determination to issue coverage to any Covered Person. A Covered Person's coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. “Rescind” has a retroactive effect and means the coverage was never in effect.

The Covered Person will be provided at least thirty (30) calendar days’ notice before rescinding coverage.

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.

Statement of Non-Discrimination

Antidote complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Antidote does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Antidote:

- 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).
- 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, contact Antidote at the toll-free number on Your ID Card.

If You believe that Antidote has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, You can file a grievance with:

Antidote
Attn: Member Services, Antidote Health Plan
[PO Box 39638
Solon, OH 44139]

or by calling the toll-free number on Your ID Card or faxing 347-296-3528.

You can file a grievance by mail, fax, or email. If You need help filing a grievance, Antidote is available to help You.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for 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, DC 20201 , 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

CONTINUATION OF GROUP COVERAGE

Group Members may be eligible to continue coverage under the Group Contract in accordance with state law if: You were enrolled in a Group which has 2 – 19 eligible employees; You experience a qualifying event which would cause You to lose coverage under Your Group; You were enrolled in Group Plan for at least 3 months before qualifying event; and You elect coverage as provided by Arizona law. Below is a summary of continuation coverage.

- **Qualifying Events:** Qualifying events that may entitle You to continued coverage are as follows:
    - Termination of the Group Member's employment (for reasons other than gross misconduct).
    - Reduction in the Group Member's work hours.
    - The Group Member's divorce or legal separation.
    - Death of the Group Member.
    - The Group Member's entitlement to Medicare.
    - Loss of status as an eligible Dependent.
- **Period of Continued Coverage:** In most cases, continuation coverage is effective on the date following the day Group coverage ends. In most cases, it ends 18 or 36 months from the date of the qualifying event, depending on the type of qualifying event.
- **Enrollment:** To enroll, You must complete an election form and return it to Your Group. The form must be returned within 60 calendar days from Your date of termination of Group coverage or Your notification (by Your Group) of eligibility, whichever is later. If You do not return the completed form, it will be considered a waiver. This means You will not be allowed to continue coverage in this Plan under a Group Policy.
- **Plant Closing:** Group Members who lose eligibility for coverage under a Group Policy due to a plant closing or a partial plant closing (as defined by law) may be eligible to continue coverage under the Group Policy for up to 90 calendar days after the plant closing. The Group Member and the Group will each pay their share of the Premium cost for up to 90 calendar days after the plant closing. The Group is responsible to notify Group Members of their eligibility. Call Your Group for further information.

Group Members may be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) if: You were enrolled in a Group which has 20 or more eligible employees; You experience a qualifying event which would cause You to lose coverage under Your Group; and You elect coverage as provided by federal law. Below is a summary of continuation coverage.

- **Qualifying Events:** Qualifying events that may entitle You to continued coverage are as follows:
    - Termination of the Group Member's employment (for reasons other than gross misconduct).
    - Reduction in the Group Member's work hours.
    - The Group Member's divorce or legal separation.
    - Death of the Group Member.
    - The Group Member's entitlement to Medicare.
    - Loss of status as an eligible Dependent.

- **Period of Continued Coverage:** In most cases, continuation coverage is effective on the date following the day Group coverage ends. In most cases, it ends 18 or 36 months from the date of the qualifying event, depending on the type of qualifying event.
- **Enrollment:** To enroll, You must complete an election form and return it to Your Group. The form must be returned within 60 calendar days from Your date of termination of Group coverage or Your notification (by Your Group) of eligibility, whichever is later. If You do not return the completed form, it will be considered a waiver. This means You will not be allowed to continue coverage in this Plan under a Group Contract.

Divorce or Separation:

- In the event of a divorce or legal separation, the person who was the Spouse of the enrollee prior to the divorce or legal separation will remain eligible for coverage in this Plan under the enrollee's Group Contract, whether or not the judgment was entered prior to the Effective Date of the Group Contract.
- This coverage requires no additional Premium other than the normal cost of covering a current Spouse.
- The former Spouse remains eligible for this coverage only until the first to occur of the following: the enrollee is no longer required by the judgment to provide health insurance for the former Spouse; or the enrollee or former Spouse remarries. If the enrollee remarries, and the judgment so provides, the former Spouse may continue coverage under the Plan in accordance with Arizona law.

ERISA INFORMATION FOR GROUP MEMBERS

When the Group purchases the policy to provide coverage under a benefit plan governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 et seq., We are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If You have questions about Your welfare benefit plan, You should contact the Group. If You have any questions about this statement or about Your rights under ERISA, contact the nearest area office of the Employee Benefits Security Administration, U. S. Department of Labor.

SECTION XV – EXHIBIT A

[Final approved Appeals Packet will be included]