ANTIDOTE

Antidote Health Plan of Ohio, Inc.

Individual Medical HMO Evidence of Coverage

[888-623-3195

1460 Broadway Street

New York, NY 10036]

Effective Date: January 1, 2027

NOTICE

This is Your individual direct payment Plan for coverage issued by Antidote.

This Plan, together with the Schedule of Benefits, applications and any amendment or rider amending the terms of this Plan, constitute the entire agreement between You and Us.

IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

This Plan is not a Medicare supplement Plan. This Plan is governed by the laws of the State of Ohio.

Please read Your contract carefully. It is Your responsibility to understand the terms and conditions in this Plan. If You are not satisfied, return this contract to Us or to Our agent within ten (10) days after You receive it. All Premiums paid will be refunded, less claims paid, and the contract will be considered null and void from the Effective Date.

Signed for Antidote Health by:

[Avihai Sodri]

[Avihai Sodri, CEO]

Table of Contents

SECTION I – INTRODUCTION 3

SECTION II – DEFINITIONS 7

SECTION III – MEMBER RIGHTS AND RESPONSIBILITIES 20

SECTION IV – HOW YOUR PLAN WORKS 21

SECTION V – COVERED HEALTH CARE SERVICES 31

SECTION VI – EXCLUSIONS AND LIMITATIONS 67

SECTION VII – WELLNESS AND REWARDS PROGRAM 70

SECTION VIII – WHO GETS BENEFITS 70

SECTION IX – TERMINATION 75

SECTION X – COST SHARING AND PAYMENT OBLIGATIONS 78

SECTION XI – PRIOR AUTHORIZATION 81

SECTION XII – CLAIMS AND REIMBURSEMENT 83

SECTION XIII – APPEALS AND COMPLAINT PROCEDURES 84

SECTION XIV – SUBROGATION AND RIGHT OF REIMBURSEMENT 87

SECTION XV – COORDINATION OF BENEFITS 89

SECTION XVI – GENERAL PROVISIONS 93

SECTION I – INTRODUCTION

This document is Your Evidence of Coverage ("EOC") which outlines Your benefits, coverage details, Exclusions, and termination provisions under the Plan. Your EOC should be read together with Your Schedule of Benefits 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 Plan 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.

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. Individuals 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/member] 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 V – 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 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/find-a-doctor]. 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 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.

You can also visit our website to search for a Network pharmacy, dentist or a vision specialist.

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. We will designate a virtual Primary Care Provider. You may also designate a Primary Care Provider from the Network Provider and include the provider’s name in Your app. Call the Provider’s office if You want to make an appointment and to validate that the provider is contracted with Us. 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 enroll, We will mail You an ID Card and a Welcome Letter after We receive Your completed enrollment materials, and You have paid Your initial Premium payment, which is referred to as the “binder payment.” This card is proof that You are enrolled in an Antidote Plan. You need to always keep this card with You. Please show this card every time You go for any health care service under the contract, including to a Network Pharmacy.

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 an individual's eligibility for benefits under the Plan, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage;
    - A determination that a health care service is not a covered benefit;
    - The imposition of an Exclusion, including Exclusions for pre-existing conditions, source of injury, Network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant;
- 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 Plan for a description of how the Allowed Amount is calculated.

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

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.

Autism Spectrum Disorder: means any of the pervasive developmental disorders – not otherwise specified, Asperger's Syndrome, or Autism Spectrum Disorder as defined by the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual available at the time an individual is first evaluated for suspected developmental delay. The diagnosis of Autism Spectrum Disorders refers to assessments, evaluations, or tests in order to diagnose when You have an Autism Spectrum Disorder. Treatment for Autism Spectrum Disorders refers to care prescribed or ordered by a Provider, including Medically Necessary requirement for such care, including, but not limited to, psychiatric care, psychological care, habilitative or rehabilitative care, including Applied Behavioral Analysis therapy, therapeutic care and pharmacy care.

Balance Billing: When a Network 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: The twelve (12) months that We will pay benefits for Covered Services. If Your coverage ends before this length of time, then the Benefit Period also ends. The Benefit Period or Plan Year begins on Your Effective Date, which means it may not correspond with the calendar year.

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 Policyholder'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 Plan.

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 Policyholder, including covered Dependents, who are properly enrolled by the Marketplace and/or Antidote, as the case may be, 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 Plan.

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 Policyholder's Spouse or Children, who are covered under the Plan, 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 Plan.

Eligible Non-Citizen: Eligible Non-Citizen is an alien lawfully present in the United States and eligible for coverage under CMS rules.

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.

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.

Evidence of Coverage (EOC): refers to the Plan issued by Antidote, including the Schedule of Benefits, and any attached riders. It refers to the document which describes the agreements between You and Us. The Evidence of Coverage provides a summary of the terms of Your benefits. Evidence of Coverage may also be referred to as "Plan."

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 which We determine to be unproven. For how this is determined, see 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.

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 3922.13 of the Ohio Revised Code.

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 treatment program. Such programs offer treatment of alcohol or other Drug dependence over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as Inpatients.

Medically Necessary / Medical Necessity: See the HOW YOUR PLAN WORKS section of this Evidence of Coverage 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.

Otolaryngologist: A licensed physician who practices otolaryngology.

Out-of-Pocket Limit or Out-of-Pocket Maximum: 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, Balance Billing charges 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.

Policyholder: The person to whom this Plan is issued. The Policyholder is legally responsible for the payment of Premium and any Copayments, Coinsurance, and Deductible amounts required under this 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 Physician;
- 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 Plans requirements for Medical Necessity and appropriateness of a proposed treatment, including level of care and treatment setting, based on the clinical information provided to Us at the time of the review. 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 authorization, unless there is evidence of fraud or misrepresentation by the Provider.

Please be advised that an approval of a Prior Authorization request is not a guarantee of payment for the rendered services.

Final payment for any authorized service is contingent upon all other terms, conditions, limitations, and exclusions of your health plan as described in this Evidence of Coverage. This includes, but is not limited to:

- Your eligibility and coverage status being active on the date the service is received.
- The specific benefits, limitations, and exclusions of Your particular Plan.
- Your satisfaction of any applicable cost-sharing responsibilities, such as deductibles, copayments, and coinsurance.
- Coordination of benefits with any other health coverage You may have.

It is Your responsibility, in coordination with Your Provider, to understand Your Plan's benefits and Your potential out-of-pocket costs before receiving care.

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 Plan 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.

- **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; Free-Standing Emergency Room; Hospice; Home Health Care Agency; a comprehensive care center for eating disorders pursuant to state law.
- **Free-Standing Emergency Room (FSER)** – A state-licensed healthcare facility that is physically separate from a Hospital but is equipped and staffed to provide emergency medical services 24 hours a day, 7 days a week.
- **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 Physician.
- **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 with one or more Physicians available at all times and every patient is under the care of a Physician;
    - 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 or pursuant to a Single Case Agreement entered into with the lab Provider on Your behalf.
- **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 You are traveling outside the Service Area of Your Plan and You require prompt medical attention to prevent the condition from worsening or when approved 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 Physician's order.
- **Physician** – Means a doctor of medicine; doctor of osteopathy; Maxillofacial surgeons; 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 Provider (PCP)** – A Network Provider who typically is an internal medicine, family practice, general practice, obstetrics/gynecology, geriatrics, or pediatric provider 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.
- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices -** A licensed individual or entity, other than a Physician or hospital, that is legally authorized to provide prescribed medical equipment and devices to You. A Supplier must meet all state and federal requirements
- **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.

Recovery: A Recovery is money You receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision because of injury or illness caused by another. Regardless of how You or Your Authorized Representative or any agreements characterize the money You receive; it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Referral: A recommendation given to one Network Provider from another Network Provider (usually from a PCP to a Network Specialist) 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.

Related Services: Services necessary to assess, select, and appropriately adjust or fit a Hearing Aid to ensure optimal performance.

Residential Treatment: A continuous and structured Inpatient program for Mental Health Conditions and/or Substance Use, which is covered only when provided in a facility licensed to deliver this specific level of care. The program must include:

- Twenty-four (24) hour-a-day nursing care, supervision, and rehabilitation;
- Individualized and intensive treatment, including observation and assessment by a Psychiatrist at least weekly; and
- A comprehensive mix of therapy, education, and recreational or social activities.

Schedule of Benefits: A document, incorporated by reference in this Evidence of Coverage 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 Ohio, in which We provide coverage.

Spouse: The person to whom the Policyholder 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.

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

Telehealth: Health care services provided through the use of 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 either the patient is receiving the services or another Health Care Provider with whom the Provider of the services is consulting regarding the patient.

Therapeutic Abortion: An abortion which, in the professional medical judgment of the patient's treating Physician, is necessary to protect the pregnant patient's life or health. In accordance with the Ohio Constitution, this definition applies particularly to a post-viability pregnancy, where such a determination by the Physician is the legal standard for the procedure. The determination of a threat to the patient's "health" includes all factors relevant to their well-being, encompassing both physical and mental health conditions.

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 Plan.

UCR (Usual, Customary and Reasonable): The reimbursement rate for a medical service in a geographic area based on what Providers in the area are usually reimbursed for the same or similar medical service.

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 single case 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 Plan.

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 select a health plan or switch health plans, within the guidelines, without any threats or harassment.
- 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

You have 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's insolvency or ends operations, You are protected only to the extent that the hold harmless provision required by the Ohio Revised Code section 1751.13 applies to the health care services rendered. This hold harmless provision states that except for a Deductible, Copayment, Coinsurance and non-Covered Services, Network Providers may not bill You for Covered Services.

If You are receiving an Active Course of Treatment from Network Providers when Antidote ends operations or is declared insolvent, Covered Services will continue to be provided by Network Providers as needed to complete any Medically Necessary procedures and follow-up care for that Active Course of Treatment. If You are receiving Inpatient services at a Network Hospital, Your coverage for such Inpatient services will be continued for up to thirty (30) calendar days after the Plan's insolvency or end of operations.

In the event of Antidote's insolvency or end of operations, You may have to pay for health care services You receive from an Out-of-Network Provider, whether Antidote authorized the use of the Out-of-Network Provider. If You need additional information, call Member Services at the toll-free number on Your ID Card.

You may be eligible for coverage under the Ohio Life & Health Insurance Guaranty Association. The association protects life and health insurance policies as well as annuity contracts in the

event of insolvency. Coverage may not be provided if other coverage is available and is conditioned on continued residence in this state. It will be subject to substantial limitations and exclusions. We and any of Our agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or health insuring corporation coverage. The Policyholder should not rely on coverage under the association when selecting a health insurer.

If You have questions, You may write to the Ohio Life & Health Insurance Guaranty Association at 485 Metro Place South, Suite 270, Dublin, OH 43017 or the Ohio Department of Insurance at 50 W Town St Third Floor, Suite 300, Columbus, OH 43215.

Additional information on the Ohio Life & Health Insurance Guaranty Association can be found at [www.olhiga.org].

Choosing a Primary Care Provider (PCP)

You must select a Primary Care Provider, who is in the Service Area, to obtain benefits. A Primary Care Provider may also be referred to as a PCP. A Primary Care Provider 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 may select a Primary Care Provider who is in the Service Area, for that Child. For Children, You may designate a pediatrician as the Primary Care Provider.

Specialists

A wide range of Specialists are included in the Antidote Network. You do not need a Referral to receive care from an In-Network 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. Failure to obtain authorization prior to seeking services from an Out-of-Network Provider may result in a denial of benefits

Standing Referrals

You may also request a standing Referral from Your Primary Care Provider. Your Primary Care Provider 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 Provider 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 Provider, and the Specialist. The treatment plan may limit the number of visits to the Specialist, limit the period for which the visits are authorized, or require the Specialist to provide Your Primary Care Provider with regular reports on the health care provided to You. Within three (3) business days of Our receipt of Your request, We will decide 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 Provider. In addition, such a Referral will be available if Your

Primary Care Provider 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 Provider, 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 Medically Necessary care to Stabilize Your condition, You should notify Us as soon as reasonably possible by calling the 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, or as soon as reasonably possible. You do not need prior approval for Emergency Services.

After Hours Care

If You need care after normal business hours, Your Physician 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. You can also schedule an Urgent Care appointment in your App with an Antidote virtual care Provider.

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. You may be responsible for the difference between the Out-of-Network Provider's charges and the amount allowed by Antidote for the Medically Necessary Out-of-Network services, but not when the service is received from an Out-of-Network Provider in a Network Facility. This amount is in addition to any applicable Copayment, Coinsurance and Deductible. 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.

Ohio Revised Code Sections 3902.50 through 3902.54, Ohio Administrative Code Section 3901-8-17, 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 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 Usual, Customary and Reasonable rate for the service, or at the median of Antidote's contracted rates for the service where permitted by law, less any patient Coinsurance, Copayment, or Deductible responsibility under the Plan; and
- when issuing payment, provide You with an explanation of benefits.

You will not be responsible for paying any amount over what You would have paid had the services been provided by a Network Provider.

Utilization Review Decisions, Timeframes and Procedures

Our Utilization Management program ensures that medical and behavioral health services provided to members are:

- Medically necessary,
- Provided in the most appropriate setting,
- Consistent with recognized standards of care, and
- Delivered in a timely manner.

UM Activities include Prior Authorization (precertification), concurrent review and retrospective review. We do not use financial incentives to encourage denials or underutilization. There are no

rewards tied to issuing adverse determinations.

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

Review Type	Determination Timeframe	Notification Timeframe
Urgent (expedited) Prior Authorization	As soon as possible, plan standard is ≤ 48 hours of receipt	Within the same 48-hour period
Standard (non-urgent) Prior Authorization	Within 7 calendar days of receipt*	Within 7 calendar days
Concurrent review (Inpatient/ongoing care)	Urgent: within 24 hours of receipt of needed clinicals; otherwise within 72 hours	Same as determination
Post-service (retrospective) review	Within 30 calendar days of receipt	Within 5 business days

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 ID Card or locate it on our website at [antidotehealth.com/member].

Prior Authorization for Inpatient and Outpatient Services

Prior Authorization is required for all non-emergency Inpatient admissions to be eligible for benefits. The list of services subject to Prior Authorization can be accessed online at [antidotehealth.com/member].

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

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 locate information 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 balance billing You for services denied for no Prior Authorization.

Emergency Admissions Notification

For admissions that occur following an emergency room visit, the hospital must notify Us at the point of stability, unless a shorter or different timeframe is specified in the Provider's agreement or required by state regulation.

Provider Submission Timeframes

To minimize the potential for care delays, We recommend that Prior Authorization requests be

received within the following timeframes when feasible:

Service Type	Provider Action/Required Timeframe
Scheduled (elective) Inpatient admissions	Submit Prior Authorization at least 5 days before the scheduled admission.
Elective outpatient services/procedures	Submit Prior Authorization at least 10 days before the service date.
Emergent Inpatient admissions	Notify Us at the point of stability. Emergency services do not require Prior Authorization.
Observation ≤ 48 hours (Out-of-Network Providers)	Notify Us within 24 hours.
Observation > 48 hours	If You remain in observation >48 hours, ask Your Provider to submit an Inpatient Provider Authorization by the next business day.
Maternity admissions (Routine Delivery)	Notify Us prior to the delivery and within 1 day after the delivery. Prior Authorization is not required for routine vaginal or cesarean delivery. Notification supports the newborn's timely enrollment in the Plan.
Newborn admissions	Notify Us within 1 day and ask Your Provider to submit clinicals and a Prior Authorization if the newborn requires ongoing Inpatient or NICU level of care.
NICU admissions	Notify Us within 1 day and submit clinical documentation for concurrent review.
Outpatient dialysis	Notify Us 1 day prior to initiation of dialysis.
Organ transplant initial evaluation	Submit Prior Authorization to Us at least 30 days before the evaluation.
Clinical trial services	Submit Prior Authorization to Us at least 30 days before commencement of 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 must notify Us (or Our delegated Utilization Review agent) within 24 hours to coordinate ongoing post stabilization care and transfer to a Network Provider is clinically appropriate.
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 Ohio 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 a grievance or reconsideration 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.

In cases where the Provider or You will not release necessary information, Antidote may deny authorization 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 for lack of Medical Necessity, 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, the claim was not payable due to Coordination of Benefits (COB) rules with another insurer, the services ultimately rendered were different from the services that were authorized by the Plan, 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 Plan;
- 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.

See the APPEALS AND COMPLAINT PROCEDURES section of this Evidence of Coverage 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.

Telehealth

Your coverage includes Telehealth 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

We will notify You by mail within fifteen (15) business days after the Effective Date of the termination of a contract with a Provider, or within fifteen (15) business days of Us becoming aware of such change, if You, or a Dependent covered under Your Plan, has received health care services from the terminated Provider within the previous twelve (12) months or if You or Your Dependent has selected the terminated Provider as Your or Your Dependent's PCP within the previous twelve (12) months.

We will pay, in accordance with the terms of the contract, for all covered health care services rendered to You by the Provider between the date of the termination of the contract and five (5) days after the notification of the contract termination is mailed to You at Your last known address.

In cases where a Network Provider is terminated without cause while You are in an Active Course of Treatment with that Provider, You may be eligible to continue treatment if You have a qualifying condition and the care is Medically Necessary. Continuity of care benefits may be available if You are:

- undergoing an Active Course of Treatment for a serious and complex condition from the Provider;
- undergoing a course of institutional or Inpatient care from the Provider;
- scheduled to undergo nonelective surgery from the Provider, including receipt of postoperative care in connection with the surgery;
- pregnant and undergoing an Active Course of Treatment for the pregnancy from the Provider; or
- determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and are receiving treatment for such illness from the Provider.

You may be eligible to continue treatment for up to ninety (90) days or until Your Active Course of Treatment is complete, depending on Your situation. Your request for continuity of care will need to be reviewed by Us to determine if Your condition qualifies and if the treatment is Medically Necessary. To request a continuity of care exception, please call Us at the toll-free number on Your ID Card.

For all other discontinuations of Provider contracts, We will make a good faith effort to provide written notice of the discontinuation thirty (30) days prior to the Effective Date of the change or otherwise as soon as practicable, to You, if You, or a Dependent enrolled under Your Plan, are a patient seen on a regular basis by the Provider whose contract is being discontinued.

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.

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.

You will be provided with thirty (30) calendar days' advance notice before Your coverage is rescinded. You have the right to request an internal appeal of a rescission of Your coverage. Once the internal appeal process is exhausted, You have the additional right to request an independent external review. See the APPEALS AND COMPLAINT PROCEDURES section for more information.

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:

1. Damage to his or her natural teeth; and
2. Expenses are incurred within twelve months of the accident, or as reasonably soon thereafter as possible or as part of a treatment plan that was prescribed by a Physician and began within twelve months of the accident, or as reasonably soon thereafter as possible. Injury to the natural teeth will not include any injury as a result of chewing or biting. Treatment for accidental dental is limited to $3,000 per occurrence.

Covered Services include, but are not limited to:

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

Note: The limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than the Physician per forming the service, or to services that We are required by law to cover.

For a Child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Ambulance Services

Ambulance transportation is considered a Covered Service only when Medically Necessary and is provided by an ambulance service (water, ground or air ambulance) that is staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals:

- From Your home, scene of accident or medical Emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and Skilled Nursing Facility; or
- From a Hospital or Skilled Nursing Facility to Your home.

Treatment of a sickness or injury by medical professionals from an ambulance service when You are not transported will be covered if Medically Necessary.

Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an employer, school, fire or public safety official and the Covered Person cannot refuse; or
- When a Covered Person is required by Us to move from an Out-of-Network Hospital to an In-Network Hospital.

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for Your condition. If none of these facilities are in Your local area, You are covered for trips to the closet facility outside Your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Covered Person's health. Any ambulance usage for the convenience of the Covered Person, family or Physician is not a Covered Service. Non-emergency ambulance transportation requires Prior Authorization. Refer to [antidotehealth.com/member] for transportation services requiring Prior Authorization.

Autism Spectrum Disorder

The Plan provides benefits for Autism Spectrum Disorders for Children up to the age of 21. These Covered Services include Medically Necessary evidence-based treatment that includes the following care prescribed or ordered by a Provider acting within their scope of practice for an individual diagnosed with an Autism Spectrum Disorder:

- Outpatient physical Rehabilitation Services including:
    - Speech and language therapy and/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.

Speech and language therapy and/or occupational Therapy Services provided under this benefit, and the associated benefit limitation, are separate from Habilitative Outpatient Services.

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 Physician’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 three (3) hours of treatment per day, and the program is available at least two (2) to three (3) days per week. The services may address 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, including for Autism Spectrum Disorder. These include Diagnostic evaluation, screening, testing and assessments, counseling, individual psychotherapy, group psychotherapy, family psychotherapy, psychiatry, behavioral health therapy home visit for Autism Spectrum Disorder 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.

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.

The Chiropractic and Osteopathic Services benefits limits described in this EOC and Your Schedule of Benefits do not apply to Therapy Services for the treatment of a Mental Health Condition, including Autism Spectrum Disorder, or for the treatment of Substance Use.

Note: We cover chiropractic, physical therapy, and occupational Therapy Services in accordance with Ohio Revised Code 3902.63. Cost-Sharing for chiropractic, physical therapy and occupational therapy will not be greater than the Cost Share for a primary care office visit.

Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-

threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted;
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when We determine the clinical trial meets the qualifying clinical trial criteria stated below;
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when We determine the clinical trial meets the qualifying clinical trial criteria stated below; or
- Other diseases or disorders which are not life threatening, when We determine the clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when You are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial. Routine patient care costs for qualifying clinical trials include:

- Covered Services for which benefits are typically provided absent a clinical trial.
- Covered Services required solely for the following:
    - The provision of the Experimental or Investigative service(s) or item.
    - The clinically appropriate monitoring of the effects of the service or item, or
    - The prevention of complications.
- Covered Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigative service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigative service(s) or item. The only exceptions to this are:
    - Certain Category B devices.
    - Certain promising interventions for patients with terminal illnesses.
    - Other items and services that meet specified criteria in accordance with Our medical and drug policies.
    - Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
    - A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
    - Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It meets any of the following criteria in the bulleted list below.

Federally funded trials. The study or investigation is approved or funded (which may include funding through in- kind contributions) by one or more of the following:

- National Institutes of Health (NIH). Includes National Cancer Institute (NCI).
- Centers for Disease Control and Prevention (CDC).
- Agency for Healthcare Research and Quality (AHRQ).
- Centers for Medicare and Medicaid Services (CMS).
- A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- The Department of Veterans Affairs, the Department of Defense, or the Department of Energy if the study or investigation has been reviewed and approved through a system of peer-review. The peer-review system is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer-review of studies and investigations used by the National Institutes of Health.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the (FDA).
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (IRBs) before You are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Service and is not otherwise excluded under this Plan.

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

<u>Diabetes Self-Management Training and Education Services</u>

"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. Diabetes self-management training and educational services does not include programs with the primary purpose of weight reduction. Benefits also include medical eye exams (dilated retinal exams) and preventive foot care, and diabetic specific foot orthotics, orthopedic shoes, inserts, modifications and footwear 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).

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, provided You meet all the criteria for treatment.

You may receive hemodialysis in an In-Network Dialysis Facility or peritoneal dialysis in Your home from a Network Provider when You qualify for home dialysis. 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 but not limited to the following:

- X-ray and other radiology services, including mammograms 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.
- 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 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 Services rendered by an Out-of-Network Provider will be covered as a Network service, and the Covered Person will be responsible for any applicable Coinsurance, Copayment or Deductible. 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 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. This may include additional services provided as part of Outpatient observation or an Inpatient or Outpatient stay related to the original visit to receive Emergency Services.

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 Inpatient stays following Emergency Services, Prior Authorization is not required. However, You must notify Us or verify that Your Physician has notified Us of Your admission within twenty-four (24) hours or as soon as possible within a reasonable amount of time. When We are contacted, You will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling us, You may avoid financial responsibility for any stay that is determined to be not Medically Necessary.

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.

Gender Affirming Care

We provide coverage for Medically Necessary gender affirming health care services. Services are subject to Prior Authorization.

Habilitative Services

For purposes of this Benefit, Habilitative Services means skilled care services that are part of a prescribed treatment plan or 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 Physician-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.
- 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 Habilitation 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 Habilitation Services or Habilitation Services provided as part of home health or hospice care.

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.

Note: We cover chiropractic, physical therapy, and occupational Therapy Services in accordance with Ohio Revised Code 3902.63. Cost-Sharing for chiropractic, physical therapy and occupational therapy will not be greater than the Cost Share for a primary care office visit.

Hearing Aid

- We provide wearable Hearing Aid and related services to individuals up to age 22.
- One Hearing Aid per hearing-impaired ear, with no Cost Share up to $2,500 every 48 months and You were verified as being deaf or hearing impaired by a licensed audiologist, Otolaryngologist or other licensed physician.
- All Related Services prescribed by an Otolaryngologist or recommended by a licensed audiologist and dispensed by a licensed audiologist, a licensed hearing aid dealer or fitter, or an Otolaryngologist will be covered with no Cost Share.
- You may choose a higher priced Hearing Aid and must pay the difference in cost above the $2,500 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.
- Antidote is not required to pay a claim for the cost of a Hearing Aid if, less than 48 months prior to the date of the claim, You received the coverage from any health benefit plan.

Note: If You have a Health Savings Account (HSA) eligible Plan, the Hearing Aid benefit is subject to Deductible.

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 but are not limited to:

- 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 be assigned and supervised by a professional nurse on the staff of the home Health Care Provider.

- Therapy Services.
- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).
- Private Duty Nursing.

Non-Covered Services include but are not limited to:

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

Hospice Care

The Plan provides benefits for Hospice Care if You have a terminal illness. Hospice Care may be provided in Your home or at a Hospice organization where medical, social, and psychological services are given to help treat individuals with terminal illnesses. Hospice Care includes routine home care, continuous home care, Inpatient Hospice, and Inpatient respite.

To be eligible for a Hospice Care program, You must have a terminal illness and a life expectancy of six (6) months or less, as confirmed by Your attending Physician. Benefits will continue if You live longer than six (6) months. Hospice services that qualify as Covered Services include the following:

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

Hospital – Inpatient Stay

Services and supplies provided during an Inpatient stay in a Hospital. 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.
- Physician Services You receive during an Inpatient stay, as follows:
    - Physician visits that are limited to one (1) visit per day by any one Physician.
    - Intensive medical care for constant attendance and treatment when Your condition requires it for a prolonged time.
    - Concurrent care for a medical condition by a Physician who is not Your surgeon while You are in the Hospital for surgery. Care by two (2) or more Physicians during one (1) Inpatient stay when the nature or severity of Your condition requires the skills of separate Physicians.
    - A consultation, which is personal bedside examination by another Physician, when requested by Your Physician.
    - Surgery and the administration of general anesthesia.
    - Newborn exam. A Physician other than the Physician who performed the obstetrical delivery must do the examination.
    - When You are transferred from one Hospital or Facility to another Hospital or Facility on the same day, any Copayment per admission is waived for the second admission.

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.

Mammography Screening

Covered Service expenses under this benefit are provided for two screening mammography views per breast to detect breast cancer in Covered Persons. A screening mammography means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic Covered Person and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. Coverage also includes the professional interpretation of film. Payment for the screening and any supplemental mammogram or Out-of-Network mammogram is limited to 130% of the Medicare reimbursement amount.

Coverage includes:

- One screening mammography every year, including digital breast tomosynthesis; and
- 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 established by the American College of Radiology, that the woman has dense breast tissue; or
    - The woman is 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 the woman's Health Care 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 prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas. Four (4) post-mastectomy surgical bras per Benefit Period are covered as part of this benefit.

Maternity Services

The Plan provides benefits for Maternity Services. Maternity Services include Inpatient services, Outpatient Services, Physician 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 may require Prior Authorization. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if You consent to such shorter stay and Your attending Physician, 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.

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 Physician 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 even if the complications are based on the service being a non-covered service.

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.
- Ostomy bags and supplies, except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

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

We cover medical foods and formulas for Outpatient total parenteral nutritional therapy; Outpatient elemental formulas for malabsorption; and dietary formula when Medically Necessary for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism.

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 Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

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.
- 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 Physician 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.

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.
- Professional services you receive from immediate relatives or household members, such as a Spouse, parent, Child, brother or sister, by blood, marriage or adoption.

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 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 the woman’s Health Care 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 Physician. You can find more information on how to access benefits

for breast pumps by contacting Us at [antidotehealth.com/member] 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/member].

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 use 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;
- 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 Physician;
- Screening mammography as described under Mammography Services;
- 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.

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 Plan.

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 Physician. 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 and may require Prior Authorization.

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.

Note: We cover chiropractic, physical therapy, and occupational Therapy Services in accordance with Ohio Revised Code 3902.63. Cost-Sharing for chiropractic, physical therapy and occupational therapy will not be greater than the Cost Share for a primary care office visit.

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** – for promoting development of speaking and listening skills after cochlear implant.
- **Cognitive Rehabilitation Therapy** – for reinstatement or improvement of cognitive function after a brain injury, including a traumatic brain injury (TBI).

Surgical Services

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

- Performance of accepted operative and other invasive procedures, including but not limited to:
    - Operative and cutting procedures;
    - Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
    - 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.

Orthognathic (jawbone) surgery for a medical condition or injury which improves function of the

joint or bone 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 Physician 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 and Lodging

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

Urgent Care

The Plan provides benefits for Covered Services received at a Network Urgent Care Center. 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 an 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 by contacting Antidote at 888-623-3195 or [antidotehealth.com]. If a referral is Medically Necessary to a Network Urgent Care Center, We will facilitate such referral.

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 Network 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.

Vision Services (All Ages)

The following vision services and materials are covered for all Covered Persons:

- Eye exams to diagnose and treat injuries and diseases of the eye(s) or related structures, subject to the Specialist office visit Cost Share listed on Your Schedule of Benefits.
- Surgical procedures to treat injuries and diseases of the eye(s) or related structures, such as cataract surgery.
- For Covered Persons with diabetes, a retinal or dilated eye exam by an optometrist or ophthalmologist once per Benefit Period. This benefit does not include refraction of the eye(s).
- One pair of prescription eyeglasses or contact lenses following cataract surgery with the insertion of an intraocular lens, subject to the prosthetics Cost Share listed on Your Schedule of Benefits. Intraocular lens(es) inserted at the time of surgery are not considered contact lenses and will not count as the one pair of contact lenses following cataract surgery. If cataracts are removed from only one eye and the Covered Person selects eyeglasses, then both lenses and frames will be covered.
- Special contact lenses for the treatment of injuries and diseases of the eye(s), when prescribed by a Network Provider and determined to be Medically Necessary. Coverage includes, but is not limited to:
    - Contact lenses for Covered Persons with congenital or acquired aphakia, such as after cataract surgery or due to injury. We cover up to six (6) Medically Necessary aphakic contact lenses per eye, per Benefit Period.
    - Scleral shell contact lenses for the treatment of diseases and injuries of the eye(s), such as aniridia.
    - FDA-approved hydrophilic contact lenses used as a corneal bandage for the treatment of diseases or injury to the eye(s), or when determined to be Medically Necessary following ocular surgery.

When a Covered Person meets the criteria above for coverage of eyeglasses or contact lenses, the associated fitting and dispensing are also covered. Benefits are limited to the amount available for basic (standard) frames and lenses.

IMPORTANT: If You opt to receive vision care services or vision care materials that are not Covered Services under this plan, a participating vision care Provider may charge You his or her normal fee for such services or materials. Prior to providing You with vision care services or

vision care materials that are not Covered Services, the vision care Provider will provide You with an estimated cost for each service or material upon Your request.

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 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.

Diabetes Supplies

We cover Medically Necessary diabetic supplies, but as with all covered medications, You are

responsible for Cost-Sharing amount as applicable. Common supplies We cover include (but are not limited to):

- Test strips specified for use with a corresponding covered blood glucose monitor;
- Lancets and lancet devices;
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein;
- Insulin and insulin analog preparations;
- Injection aids, including devices used to assist with insulin injection and needleless systems;
- Insulin syringes;
- Biohazard disposable containers;
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and
- Glucagon emergency kits.

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 or from Network retail Pharmacies for specific benefit Plans. 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].

Specialty Medications – Medication Assistance Program (MAP)

The Plan has implemented a specialty medication acquisition program for physician-administered Drugs (excluding biologics and chemotherapy medications). You have the option to fill Your provider administered specialty medications through Your Navitus Pharmacy Benefit. The advantages to You of using Navitus Pharmacy Benefit for specialty medications are:

- Potential savings by lowering out-of-pocket costs.
- When medications are processed through the Navitus Pharmacy Benefit, the billing and shipping will be coordinated by the specialty pharmacy.
- These medications are shipped directly to Your Provider's office ahead of Your appointments.
- Access to clinicians for medication-related guidance, including support in managing side effects and addressing any concerns.

If You are interested in this option, speak with Your Provider to see if accessing a specialty medication through the specialty pharmacy is right for You.

Physician-administered medications generally require Prior Authorization. Refer to [antidotehealth.com/member] for further details about the specialty medications that require Prior Authorization.

Contact the Member Services at 888-623-3195 for further information.

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. The appeal will be between the Provider and a clinical peer. We will respond to Your Provider's appeal within forty-eight (48) hours 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.

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 orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.

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 Independent Review Organization (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.

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

Except as otherwise noted in this Plan, drugs must be approved by the Food and Drug Administration (FDA) for treatment of the condition for which it is prescribed in order to be covered.

We cover off-label uses when the drug is recognized for treatment of the condition for which it is prescribed by:

- the American Hospital Formulary Service Drug Information; a publication of the American Society of Health-System Pharmacists.
- 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.

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 Physician'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 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 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.
- Human growth hormone for Children born small for gestational age. It is only a Covered Service in other situations when allowed by Us through Prior Authorization.
- Compound Drugs unless there is at least one ingredient that requires a prescription.
- For medication that is to be taken by the Covered Person, in whole or in part, at the place where it is dispensed. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.

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 performed for a Covered Person by a Covered Person's immediate family.
- 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 Physician; 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.

- For cosmetic breast reduction or augmentation.
- For the reversal of sterilization and vasectomies.
- For non-therapeutic abortion.
- For expenses for television, telephone, or expenses for other persons.
- For marriage, family, or Child counseling for the treatment of premarital, marriage, family, or Child relationship dysfunctions.
- For telephone consultations, except those meeting the definition of Telehealth services, or for failure to keep a scheduled appointment.
- For dental service expenses, including braces for any medical or dental condition, surgery, and treatment for oral surgery, except as expressly provided for under the Accidental Dental benefits.
- 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 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, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this contract.
- For Hearing Aid or assistive listening device batteries, including rechargeable batteries, any size and Hearing Aid or assistive listening device cords except as expressly provided in this contract.
- 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.
- 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.

- Surrogacy/Gestational Carrier Arrangement. All pregnancy related services provided to a surrogate mother are not covered including charges related to the baby's birth, hospitalization, or care because of surrogacy. The following health care services, including related supplies and medication, to You serving as a surrogate/gestational carrier are excluded. Including but not limited to the following:
    - Mental health services related to the surrogacy/gestational carrier arrangement;
    - Expenses related to donor semen, including collection and preparation for implantation;
    - Donor gamete or embryos or storage of same 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 diagnosis relating to a surrogacy/gestational carrier arrangement;
    - Any other non-maternity care services, supplies and medication.
- 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, but not limited to:
    - 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.
- For or related to treatment of hyperhidrosis (excessive sweating).
- 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 court ordered testing or care unless Medically Necessary.
- 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.
- Bariatric surgery.
- 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.
- Speech Therapy Services, maintenance and/or non-acute therapies, or therapies where a significant and measurable improvement of condition cannot be expected in a reasonable and generally predictable period of time as determined by Us in consultation with the treating Provider. Any combination of therapies (including speech and language therapies) that exceed the maximum allowable benefits as described in the Schedule of Benefits. Communication devices (speech generating devices). Rehabilitative services relating to developmental delay, provided for the purpose of maintaining physical condition, or maintenance therapy for a chronic condition are not covered. However, rehabilitation and habilitation therapy for physical impairments in Members with Autism Spectrum Disorders that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered Medically Necessary when criteria for rehabilitation and habilitation therapy are met except as expressly provided in this contract.

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, the Policyholder to whom this Plan is issued, are covered under this Plan, subject to the applicable Premium payments, and during the grace period. You must live, work, or reside in Our Service Area to be covered under this Plan. If You are enrolled in Medicare due to age, You are not eligible to purchase 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 the Health Insurance Marketplace. Coverage begins on the date determined by the Health Insurance Marketplace and identified in this Plan if We receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An eligible person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the Health Insurance Marketplace.

Effective dates for individuals enrolling through a special enrollment period will follow the special Effective Dates outlined in 45 CFR § 155.420. A qualified individual has sixty (60) days to report a qualifying event directly to the Marketplace and could be granted a 60-day Special Enrollment Period as a result of one of the following events:

- A qualified individual or Dependent loses minimum essential coverage, non-calendar year group or individual health insurance coverage, pregnancy-related coverage, access to healthcare services through coverage provided to a pregnant enrollee's unborn Child, or medically needed coverage;
- A qualified individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or Placement for Adoption, placement in foster care, or a Child support order or other court order;
    - In the case of marriage, at least one Spouse must demonstrate having minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage.
- An individual, who was not previously a citizen, national, or Eligible Non-Citizen gains such status;
- An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
- A qualified individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
- An enrollee adequately demonstrates to the Health Insurance Marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee's decision to purchase the qualified health plan based on plan benefits, Service Area or Premium;
- An individual is determined newly eligible or newly ineligible for advanced Premium tax credit or has a change in eligibility for Cost-Sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan;
- A qualified individual or enrollee gains access to new qualified health plans as a result of a permanent move;
- Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
    - The qualifying events for employees are:
        - Voluntary or involuntary termination of employment for reasons other than gross misconduct; or
        - Reduction in the number of hours of employment.
    - The qualifying events for Spouses are:
        - Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
        - Reduction in the hours worked by the covered employee;
        - Covered employee's becoming entitled to Medicare;

        - Divorce or legal separation of the covered employee; or
        - Death of the covered employee.
    - The qualifying events for Dependent Children are the same as for the Spouse with one addition:
        - Loss of Dependent Child status under the Plan rules.
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- A qualified individual or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
- A qualified individual or Dependent is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
- A qualified individual or Dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than sixty (60) days after the qualifying event;
- At the option of the Health Insurance Marketplace, a qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a qualified health plan through the Health Insurance Marketplace following termination of Health Insurance Marketplace enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence;
- A qualified individual newly gains access to an employer sponsored individual coverage HRA or a Qualified Small Employer Health Reimbursement Arrangement (HRA);
- An individual provides evidence they did not enroll in a marketplace or other individual health benefit plan during the immediately preceding enrollment period because they were misinformed that they were covered under a plan with minimum essential coverage;
- An individual is a member of the reserve forces of the United States military returning from active duty or a member of the Ohio National Guard returning from active duty service under Title 32 of the United States Code.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Health Insurance Marketplace.

The Policyholder must notify Health Insurance Marketplace of a new Dependent to be added to this Plan. The Effective Date of the Dependent's coverage must follow Health Insurance Marketplace rules. Please see www.healthcare.gov/coverage-outside-open- enrollment/confirm-special-enrollment-period/. Additional Premium may also be required, and it will be calculated from the date determined by Health Insurance Marketplace.

If You are enrolled in an off-exchange Plan and apply in writing to add a Dependent Covered Person and You pay the required Premiums, We will send You written confirmation of the added Dependent Covered Person's Effective Date of coverage and ID cards for the added Dependent.

NOTE. Subject to a determination of the Health Insurance Marketplace, You or Your Spouse's eligible Child will be covered from the time of birth, adoption, regardless of the age of the Child when the Child was adopted, or the Child's placement in Your care for adoption and a certificate has been issued after the completion of an investigation conducted by the applicable agency or the person who seeks custody of the Child has filed a petition with the court pending certification until the 31st day after birth, adoption, or Placement for Adoption. The newborn Child will be covered from the time of birth or placement for loss due to injury and sickness, including loss from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional Premium will be required to continue coverage beyond the 31st day after the date of birth. The required Premium will be calculated from31 days after the birth of the Child . If notice is given by the Health Insurance Marketplace within 60 days of the birth of the Child, the contract may not deny coverage of the Child due to failure to notify Us of the birth of the Child or to pre-enroll the Child. Coverage of the Child will terminate on the 31st day after its birth, unless We have received notice by the entity that You have enrolled (either the Health Insurance Marketplace or Us).

Who Can Be Covered

- The Policyholder – You, if You are an eligible person.
- Your Spouse, under an existing marriage legally recognized under the laws of the state of Ohio.
- Your domestic partner under the terms and conditions of this Evidence of Coverage is eligible for enrollment.
- If You selected individual and Child(ren) or Family Coverage, 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;
    - Step Children;
    - 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 Us. 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 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 Us. 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 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, intellectual disability, or physical disability; and
- The Dependent Child depends mainly on the Policyholder 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 Plan.
- 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 no more frequently than annually. 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 Policyholder 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 initial term of this Evidence of Coverage commences on the Evidence of Coverage Effective Date and continues through the Benefit Period. This Evidence of Coverage shall automatically be renewed thereafter from year-to-year, unless sooner terminated by the Policyholder or Us as set forth below.

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 otherwise receiving medical treatment on that date. If You are hospitalized when coverage ends, coverage will be extended to the earliest occurrence of any of the following:

- Your discharge from the Hospital;
- The determination by Your attending Provider that Inpatient care is no longer medically indicated for You;
- You reach the limit for contractual benefits;
- The Effective Date of any new coverage.

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 Policyholder's coverage ends. We will refund any Premium paid and not earned due to Plans termination.

This Evidence of Coverage may also terminate due to changes in the actuarial value requirements under state or federal law. If this Evidence of Coverage terminates for this reason, a new Evidence of Coverage, if available, may be issued to You.

You may keep coverage in force by timely payment of the required Premiums, subject to the grace

period, under this Plan or under any subsequent coverage You have with Us.

This Plan will renew on January 1 of each calendar year. However, We may refuse renewal if any of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where You then live, as explained under The Entire Plan Ends below;
- There is fraud or intentional misrepresentation made by You or with Your knowledge in filing a claim for benefits, as explained under the section below named Fraud or Intentional Misrepresentation of a Material Fact; or
- Your eligibility would otherwise be prohibited under applicable law.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **Non-payment of Premium**
    - Your coverage ends on the last day of the Grace Period if all outstanding Premiums were not paid in full.
        - You have the right to appeal Our decision if You believe Your coverage was wrongfully terminated.
        - Outside Open Enrollment, You don't qualify for a Special Enrollment Period if You lose coverage due only to non-payment of Premium; however, You may qualify for other reasons.
        - If Your coverage ends due to non-payment and You are not enrolled in Marketplace coverage in mid-December of that year, You are not eligible to be automatically re-enrolled for the following year.
        - When You apply and are found eligible to enroll in a Marketplace plan, You may be able to enroll in the same plan You lost if it is still available. If We have clearly described, in writing, the consequences of non-payment on future enrollment before Your loss of coverage, We may require You to pay any past-due Premium amounts You owe Us for coverage in the past twelve (12) months.
        - Whether You choose a new plan or the plan You were terminated from, You must pay Your first month's Premium to Us to complete Your enrollment.

- **The Entire Plan Ends**
    - Your coverage ends on the date this Plan ends. That date will be one of the following:
        - The date determined by the Health Insurance Marketplace that this Plan will terminate because the Policyholder no longer lives in the Service Area;
        - The date We specify, after We give You ninety (90) days prior written notice, that We will terminate this Plan 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 Plan because We will discontinue offering and refuse to renew all individual policies/certificates in the individual 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 a Policyholder or an enrolled Dependent, as determined by the Health Insurance Marketplace. 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 Health Insurance Marketplace rules if We receive notice from the Health Insurance Marketplace instructing Us to end Your coverage. Your coverage ends on the date determined by the Health Insurance Marketplace rules if We receive notice from You instructing Us to end Your coverage.

Other Events Ending Your Coverage

When any of the following happen, We will provide written notice to the Policyholder 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 Policyholder 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 Plan.

- **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 Plan. 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.

Reinstatement

If the Plan is terminated because You didn’t pay Your Premium in the time allowed, We may agree to reinstate coverage under this Plan upon Your request and Our discretion. If We do reinstate the Plan, We will only provide benefits for the period prior to termination or after reinstatement. Benefits will be suspended prior to the date of reinstatement. You and Antidote

will have the same rights as existed right before the due date of the missed Premium. Additionally, this is subject to any amendments or endorsements attached to the reinstated Plan. All Premiums that We accept in connection with Your reinstatement will be applied to the period for which You haven't already paid Premium. If You or Your Dependent(s) are deployed or called to active duty in the U.S. Military, and want to be reinstated upon Your return, We will provide You with the same benefits in effect before the Plan lapsed. We won't increase Your Premium unless rate increases are applicable to all Plan holders.

Refunds after Termination

When a Covered Person's coverage is terminated any periodic payments received on account of the terminated Covered Person applicable to periods after the Effective Date of termination, less any amounts due to Antidote or Network Providers for coverage and/or Covered Services provided prior to the date of termination, shall be refunded or credited to the Covered Person. Neither Antidote nor Network Providers shall have any further liability under this Plan.

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

You and/or Your Dependents have the right to continuation of Your insurance if Your eligibility under this Plan would terminate due to the Policyholder's death, Your divorce from the Policyholder or if other Dependents would become ineligible due to age or no longer qualify as Dependents under this Plan, unless You have failed to pay the Premium. Your coverage will continue provided that the Covered Person exercising the continuation right notifies Antidote 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.

Grace Period

If You do NOT receive federal health insurance subsidies (Advance Premium Tax Credits and/or Cost-Sharing reduction subsidies) You shall have a thirty-one (31) day grace period in which to pay Premium after it becomes due. If payment of the appropriate Premium is not made within the thirty-one (31) day grace period, the Plan will be terminated by Us on the last day of the grace period. This grace period does not apply to Your first month's Premium payment.

If You receive federal health insurance subsidies (Advance Premium Tax Credits and/or Cost-Sharing reduction subsidies), You shall have a three (3) month grace period in which to pay Premium after it becomes due. If payment of the appropriate Premium is not made within the three (3) month grace period, the Evidence of Coverage will be terminated by Us retroactive to the last day of the first month of the three (3) month grace period. This grace period does not apply to Your first month's Premium payment.

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 Our Plan will require 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 Our Plan will require 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;
- Expenses not covered because a Benefit Period Maximum has been reached; and
- Any Covered Services expenses paid by the primary Plan when We are the secondary Plan for purposes of coordination of benefits.

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.

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
- Except for 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.

Payment of Premiums

Payment of monthly Premiums for coverage under this Plan shall be made by You or a third

party listed below. Premiums shall be remitted on a monthly basis to Us within the specified time frames set forth in this Plan. Only a Covered Person for whom the Premium is actually received by Us, who has met all other applicable provisions of this Plan, and who has been accepted by Us, shall be entitled to coverage under this Plan and only for the month for which such Premium is received except with respect to newborn Child coverage, which is automatically provided under this Plan for the first thirty-one (31) days.

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.
- From an employer when only ICHRA is offered to all of the employer's employees.

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 Us to You. We will notify You at the last address known to Us, 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 Ohio Department of Insurance.

Misrepresentation Regarding Tobacco Use

If a Covered Person makes an intentional misrepresentation of a material fact regarding the use of tobacco on the Policyholder 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 You for the difference in Premium. We will not terminate Your Plan 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. 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 a 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 www.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:

1. Receives a service or supply from an Out-of-Network Provider;
2. Are admitted into a Network Facility by an Out-of-Network Provider; or
3. 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.
- Within twenty-four (24) hours of any Inpatient admission, including emergent Inpatient admissions.
- 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 by conducting a peer-to-peer review. The Provider or Facility may not request reconsideration without Your prior written consent.

The reconsideration shall occur within three (3) business days after We receive the written request for reconsideration, and shall be conducted between the Provider or Facility rendering the Covered Service and the reviewer who made the Adverse Benefit Determination; however, if Our reviewer is not available, the reviewer may designate another reviewer. For requests for reconsideration related to an Urgent Care review, We shall review such request in a timeframe that takes into account the medical urgency. Reconsideration is not required before You pursue an internal or external review of an Adverse Benefit Determination. Your Provider must have Your written consent in order to conduct this peer-to-peer review with the Plan's reviewer or the Plan's designee.

Note: Additional information is available in the section entitled "Utilization Review Decisions, Timeframes and 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: [mailing address].

Notice of Claim

We must receive notice of claim within thirty (30) days of the date the loss began or as soon as reasonably possible.

Proof of Loss

We must receive written proof of loss within ninety (90) days of the loss or as soon as is reasonably possible. Proof of loss furnished more than one year late will not be accepted, unless You or Your covered Dependent had no legal capacity to submit such proof during that year. If We do accept the proof of loss after a year, We will then process the proof of loss within ninety (90) days.

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.

Payment of Benefits

We will pay or deny a claim within thirty (30) calendar days after We receive a claim that includes all of the information necessary to process the claim. If additional supporting information is required to process the claim, We will notify the applicable person(s) within fifteen

(15) calendar days after receipt of the claim. This notice will detail the supporting documentation needed. The timeframe for processing this claim is then extended to forty-five (45) calendar days. The days that elapse between the notification and receipt of the requested documentation are not counted as a part of the forty-five (45) day calendar period. You and Your Provider will be notified when a claim is denied. The notification will include the reason(s) for the denial.

Explanation of Benefits

After You receive 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.

Time of Payment of Claims

After receiving a claim form, We will either make a request for additional information or make a coverage decision within thirty (30) days. Payment of claims benefits will be paid to You. We may pay all or a portion of any indemnities provided for health care services to the health care services Provider, unless You direct otherwise in writing by the time claim forms are filed. We cannot require that the services are rendered by a particular health care services Provider, except that the Provider must be in In-Network where possible.

Unpaid Premium

At the time of payment of a claim under this Plan, any Premium then due and unpaid may be deducted from the claim payment.

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

The appeals process is intended to solely address appeals of Adverse Benefit Determinations. This process is distinct from the Grievance Procedure described above.

Internal Appeal Process

You have the right to file an Internal Appeal with Us if You disagree with or are dissatisfied with an Adverse Benefit Determination We have made. Your Internal Appeal may be submitted by You or Your Authorized Representative. The timing of decisions and notifications related to such Internal Appeals are provided below. You or Your Authorized Representative must submit Your Internal Appeal to Us within one hundred eighty (180) days of receiving the Adverse Benefit Determination. All Internal Appeal requests must be in writing, except for an Internal Appeal request involving Urgent Care, which may be requested orally or electronically. You or Your Authorized Representative may send a written request for an Internal Appeal to: Antidote, Attention: [insert mailing address]. Fax: [xxx-xxx-xxxx]. Expedited Fax: [xxx-xxx-xxxx].

For internal appeals not requiring an expedited timeline, the appeal will be considered within ten (10) calendar days after We receive it.

Expedited Internal Appeal

You can file an expedited appeal when a requested service involves a situation that would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function. This type of appeal must be documented with clinical information.

You may request an expedited appeal at any time. You may start the appeal by phone or in writing. You may call the toll-free number on Your ID Card to initiate an expedited appeal request.

We will make a decision about the request within forty-eight (48) hours. We will notify You and Your Authorized Representative of the result.

External Appeal

If You, or Your Authorized Representative, are not satisfied with the final outcome of the Internal Appeal, an external appeal by an Independent Review Organization (IRO) or by the superintendent of insurance, or both, may be requested. You, or Your Authorized Representative, can request an external review when the appeal is of Adverse Benefit Determinations based on Medical Necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an external review will not affect Your healthcare services. We want to know Your concerns so We can improve Our services. An external review decision is binding on Us. An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law. We will pay for the costs of the external review performed by the independent reviewer.

A claimant may not file a subsequent request for an external review involving the same Adverse Benefit Determination that has been previously reviewed unless new medical and scientific evidence is submitted to Us.

All requests for an external review must be made within one hundred eighty (180) days of the date of the notice of the Plan’s final Adverse Benefit Determination. Standard requests for an external review must be provided in writing; requests for expedited external reviews, including Experimental/Investigative, may be submitted orally or electronically. When an oral or electronic request for review is made, written confirmation of the request must be submitted to the Plan no later than five (5) days after the initial request was made. If the superintendent or IRO requires additional information from You or Your healthcare Provider, the Plan will tell You what is needed to make the request complete. The IRO assigned to review an Adverse Benefit

Determination shall provide written notice of its decision to either uphold or reverse the determination within thirty (30) calendar days of receipt by the health Plan issuer of a request for a standard review or a standard review involving an experimental or investigational treatment. You may file the request for an external review by contacting the Plan:

[Address]
[Phone number/TDD/TTY]
[Fax]

Urgent Request for an External Appeal

If an expedited external review (urgent) was requested, the IRO will provide a determination as soon as possible or within seventy-two (72) hours of receipt of the expedited request.

Non-Urgent Request for an External Appeal

Unless the request is for an expedited external review, the Plan will initiate an external review within five (5) days after it receives Your written request if Your request is complete. The Plan will provide You with notice that it has initiated the external review that includes:

- The name and contact information for the assigned Independent Review Organization or the superintendent of insurance, as applicable, for the purpose of submitting additional information; and
- Except for when an expedited request is made, a statement that You may, within ten (10) business days after the date of receipt of the notice, submit, in writing, additional information for either the Independent Review Organization or the superintendent of insurance to consider when conducting the external review.

External Reviews for Experimental or Investigational Services

An external review for an Experimental or Investigational Service is similar to a standard or expedited external review. The most significant difference is that these are external reviews of Adverse Benefit Determinations when benefits have been denied for a health care service that We have determined to be an Experimental or Investigational Service unless the requested health care service is specifically listed as an exclusion in this Evidence of Coverage. You or Your Authorized Representative may request an external review for Experimental or Investigative Services only if Your treating Physician certifies that one of the following situations applies:

- Standard health care services have not been effective in improving the condition of the Covered Person;
- Standard health care services are not medically appropriate for the Covered Person or
- There is no available standard health care service covered under this Evidence of Coverage that is more beneficial than the requested health care service.

External Reviews Conducted by the Ohio Department of Insurance

The Ohio Department of Insurance will conduct external reviews in either of the following instances:

- The Adverse Benefit Determination notice is based on a contractual issue that does not involve a medical judgment or medical information; or
- The Adverse Benefit Determination notice involves Emergency Services that have been

determined to be not Medically Necessary or appropriate, and Our decision has already been upheld through an external review by an Independent Review Organization (IRO).

You and Antidote will provide the Department with any information it requires for the review. The Department shall determine whether the health care service is a Covered Service. The Department will then notify You and Us of its decision. If the Department determines that the health care service is a Covered Service, then We will provide coverage pursuant to the terms of the Plan. If the Department determines that the health care service is not a Covered Service, then We will not be required to cover the service or afford You the opportunity for an external review by an IRO.

Complaint/Appeals Assistance from the Ohio Department of Insurance

If You have any questions regarding an appeal or grievance concerning the health care services You have been provided, which have not been satisfactorily addressed by Your Plan, You may contact the Ohio Department of Insurance for assistance. The Ohio Department of Insurance (ODI) may be contacted as follows:

Ohio Department of Insurance
ATTN: Consumer Services Division
50 West Town Street
Suite 300, Columbus, OH 43215
Toll-Free: 800-686-1526

Information regarding the Ohio Department of Insurance may be found by accessing its website at https://insurance.ohio.gov/wps/portal/gov/odi/consumers.

Reporting a question, concern, grievance, or appeal will not affect Your health care services. These processes are available to address Your concerns.

SECTION XIV – SUBROGATION AND RIGHT OF REIMBURSEMENT

We have the right to subrogation and reimbursement. References to “You” or “Your” in this Subrogation and Reimbursement section shall include You, Your estate and Your heirs and beneficiaries unless otherwise stated. Subrogation applies when We have paid benefits on Your behalf for a sickness or injury for which any third party is allegedly responsible. The right to subrogation means that We are substituted to and shall succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that We have paid that are related to the sickness or injury for which any third party is considered responsible.

Antidote’s right of reimbursement attaches, to the fullest extent permitted by law, when Antidote has provided health care benefits for injuries or illness for which a third party is responsible and the Covered Person and/or the Covered Person’s Authorized Representative has recovered any amounts from the third party or any party making payments on the third party’s behalf. By providing any benefit under this Plan, Antidote is granted an assignment of the proceeds of any settlement, judgment or other payment received by the Covered Person to the extent of the full cost of all benefits provided by Antidote. Antidote’s right of reimbursement is cumulative with and not exclusive of Antidote’s subrogation right and Antidote may choose to exercise either or both rights of Recovery.

As a condition for Our payment, You or anyone acting on Your behalf (including, but not limited to, the guardian, legal representatives, estate, or heirs) agrees:

- To fully cooperate with Us in order to obtain information about the loss and its cause.
- To immediately inform Us in writing of any claim made or lawsuit filed on behalf of a Covered Person in connection with the loss.
- To include the amount of benefits paid by Us on behalf of a Covered Person in any claim made against any third party.
- That we:
    - Will have a lien on all money received by a Covered Person in connection with the loss to the extent permitted by state law.
    - May give notice of that lien to any third party or third party's agent or representative.
    - Will have the right to intervene in any suit or legal action to protect Our rights.

We have a first priority right to receive payment on any claim against any third party before You receive payment from that third party. Further, Our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical Providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

Your failure to cooperate with Us is considered a breach of contract. As such, We have the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits We have paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by Us due to You or Your representative not cooperating with Us. If We incur attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, We have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts You hold which should have been returned to Us.

Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You or Your representative, Your Estate, Your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help You to pursue Your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from Our Recovery without Our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

Regardless of whether You have been fully compensated or made whole, We may collect from You the proceeds of any full or partial Recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which We may collect include, but are not limited to, economic, non- economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit Our subrogation and reimbursement rights.

If a dispute arises as to the amount a Covered Person must reimburse Us, the Covered Person (or the guardian, legal representatives, estate, or heirs of the Covered Person) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by

Us until the dispute is resolved. Additionally, either party may file an action pursuant to state law to resolve any issue related to the distribution of the recovered funds.

However, if less than the full value of the loss is recovered because of comparative negligence, diminishment due to a party's liability pursuant to state law, or by reason of the collectability of the full value of the claim for injury, death, or loss to person resulting from limited liability insurance or any other cause, Our reimbursement amount shall decrease in the same proportion as the Covered Person's interest.

We will not pay attorney fees or costs associated with the Covered Person's claim or lawsuit unless We previously agreed in writing to do so.

SECTION XV – COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan as defined below. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the primary Plan. The primary Plan must pay benefits in accordance with its Evidence of Coverage terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the primary Plan is the secondary Plan. The secondary Plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total allowable expense.

Definitions – the following definitions apply to this section:

- A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Covered Persons of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.
    - Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, health insuring corporation (HIC) to comply with OAC 3901-8-01 Appendix A, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
    - Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage (as described above) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

- This Plan means, in a COB provision the part of the contract providing the healthcare benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing healthcare benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- The order of benefit determination rules determine whether this Plan is a "primary Plan" or "secondary Plan" when You have healthcare coverage under more than one Plan.

When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

- Allowable Expense is a healthcare expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable Expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable Expense. The following are examples of expenses that are not Allowable Expenses:
    - The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private Hospital room expenses.
    - If You are covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
    - If You are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
    - If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the Provider has contracted with the secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the secondary Plan to determine its benefits.
    - The amount of any benefit reduction by the primary Plan because You have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred Provider arrangements.
- Closed Panel Plan is a Plan that provides healthcare benefits to You primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or Referral by a panel member.
- Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When You are covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- The primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
- (A) Except as provided in (B), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
  (B) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.
- A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- Each Plan determines its order of benefits using the first of the following rules that apply:
    - Non-Dependent or Dependent. The Plan that covers You other than as a Dependent, (for example as an employee, Covered Person, Policyholder, or retiree) is the primary Plan and the Plan that covers You as a Dependent is the secondary Plan. However, if You are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering You as a Dependent, and primary to the Plan covering You as other than a Dependent, then the order of benefits between the two plans is reversed so that the plan covering You as an employee, Covered Person, Policyholder, or retiree is the secondary Plan and the other plan is the primary Plan.
    - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Child is covered by more than one Plan the order of benefits is determined as follows:
        - For a Child whose parents are married or are living together, whether or not they have ever been married:
            - The Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan; or
            - If both parents have the same birthday, the Plan that has covered the parent the longest is the primary Plan.
            - However, if one Spouse's Plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), We will follow the rules of that Plan.
        - For a Child whose parents are divorced or separated or not living together, whether or not they have ever been married:
            - If a court decree states that one of the parents is responsible for the Child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan Years commencing after the Plan is given notice of the court decree;
            - If a court decree states that both parents are responsible for the Child's healthcare expenses or healthcare coverage, the provisions of paragraph a. above shall determine the order of benefits;
            - If a court decree states that the parents have joint custody without

specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the Child, the provisions of paragraph i. above determine the order of benefits; or

- If there is no court decree allocating responsibility for the Child's healthcare expenses or healthcare coverage, the order of benefits for the Child are as follows:
    - The Plan covering the Custodial Parent, first;
    - The Plan covering the Spouse of the Custodial Parent, second;
    - The Plan covering the noncustodial parent, third; and then
    - The Plan covering the Spouse of the noncustodial parent, last.

▪ For a Child covered under more than one Plan of individuals who are not the parents of the Child, the provisions of paragraph i. or ii. above shall determine the order of benefits as if those individuals were the parents of the Child.

- Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the primary Plan. The Plan covering You as a retired or laid-off employee is the secondary Plan. The same would hold true if You are a Dependent of an active employee and You are a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.
- COBRA or State Continuation Coverage. If You have coverage provided under COBRA or under a right of continuation provided by state or other federal law and You are also covered under another Plan, the Plan covering You as an employee, Covered Person, Policyholder, or retiree or covering You as a Dependent of an employee, Covered Person, Policyholder, or retiree is the primary Plan and the COBRA or state or other federal continuation coverage is the secondary Plan. If the other plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.
- Longer or Shorter Length of Coverage. The Plan that covered You as an employee, Covered Person, Policyholder, Policyholder, or retiree longer is the primary Plan and the Plan that covered You the shorter period of time is the secondary Plan. If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

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

Effect on the Benefits of This Plan

- When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a calendar year are not more than the total Allowable

Expenses. In determining the amount to be paid for any claim, the secondary Plan must calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the primary Plan. The secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the secondary Plan must credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other healthcare coverage.

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

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering you. We need not tell, or get the consent of, any person to do this. To claim benefits under this Plan, You must give Us any facts We need to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

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

Coordination Disputes

If You believe that We have not paid a claim properly, You should first attempt to resolve the problem by contacting Us. Please see Section XIII – Appeals and Complaint Procedures for Our contact information. If You are still not satisfied, You may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526 or visit the Department’s website at http://insurance.ohio.gov.

SECTION XVI – 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.

Change of Beneficiary: Unless You make an irreversible designation of beneficiary, You reserve the right to change Your beneficiary. The consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Plan or to any change of beneficiary or beneficiaries, or to any other changes in this Plan.

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

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

- A major disaster or epidemic,
- An act of God,
- A nuclear explosion or accident,
- Complete or partial destruction of facilities,
- A riot,
- Civil insurrection,
- Labor disputes that are out of the control of Antidote,
- Disability affecting a significant number of a Network Provider's staff or similar causes, or
- Health care services provided under this EOC are delayed or considered impractical. Under such circumstances, Antidote and Network Providers will provide the health care services covered by this EOC as far as is practical under the circumstances and according to their best judgment; however, We and Our Network Providers will accept no liability or obligation for delay, or failure to provide or arrange health care services if the failure or delay is caused by events or circumstances beyond Our control.

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 Ohio on this contract's Effective Date or on any Premium due date is changed to conform to the minimum requirements of Ohio state law.

Coverage Effective Date: Coverage takes effect on the Effective Date shown on the cover page. 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 Plan. 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.

Incontestability: No statement made by You in an application for coverage under this Plan shall avoid the Plan or be used in any legal proceeding unless the application or an exact copy is attached to this Plan. After two (2) years from the date of issue of this Plan, no misstatements, except for fraudulent misstatements made by You in the application for coverage, shall be used to void the Plan or deny a claim.

Legal Actions: No action at law or in equity may be brought by You to recover on this Plan prior to the expiration of sixty (60) days after the required written proof of loss is given. No such action may be brought after the expiration of three (3) years after the date proof of loss is required to be furnished.

Misstatement of Age: If Your age or has been misstated, benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age.

Physical Examination: We shall have the right and opportunity to examine a Covered Person while a claim is pending or while a dispute over a claim is pending. These examinations are made at Our expense and as often as We may reasonably require.

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.

Time Limit on Certain Defenses: After two (2) years from the date of issue of this Evidence of Coverage no misstatements, except fraudulent misstatements, made by the applicant in the application for the Evidence of Coverage shall be used to void the Evidence of Coverage or to deny a claim for loss incurred or disability (as defined in this Evidence of Coverage)

commencing after the expiration of the two (2) year period. After the Evidence of Coverage has been in force for a period of two (2) years during the lifetime of the Covered Person (excluding any period during which the Covered Person is disabled), it shall become incontestable as to the statements contained in the application. For purposes of any reinstatement of this Evidence of Coverage, We may contest coverage under the Evidence of Coverage on account of the applicant's fraud or material misrepresentation only if fraud or material misrepresentation was contained in the reinstatement application, and then only for the period during which the Evidence of Coverage was reinstated.

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, [mailing address], or by calling the toll-free number on Your ID Card, or faxing [xxx-xxx-xxxx].

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].