ANTIDOTE

Antidote Health Insurance Company of Texas, Inc.

Individual Medical EPO Policy

[888-623-3195
1460 Broadway Street New York, NY 10036]

Effective Date: January 1, 2027

TEXAS DEPARTMENT OF INSURANCE – NOTICE

ENGLISH
If You have a complaint, You should first contact Antidote at the toll-free number on Your ID Card. If You still have a complaint after contacting Us, You may contact the Texas Department of Insurance to ask for assistance with Your complaint:

Toll-Free: 1-800-252-3439

Address:
Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104

To file a complaint online:
www.tdi.texas.gov

ESPAÑOL
Si usted tiene una queja, primero debe comunicarse con Antidote al número gratuito que aparece en su tarjeta de identificación. Si todavía tiene una queja después de comunicarse con nosotros,usted puede comunicarse con el Departamento de Seguros de Texas para pedir ayuda con Su queja:

Número Gratuito: 1-800-252-3439

Dirección:
Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104

Para presentar una queja en línea:
www.tdi.texas.gov

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.

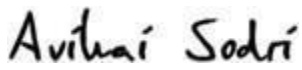
IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ THIS ENTIRE PLAN CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS PLAN.

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

This Policy is guaranteed renewable, subject to applicable federal and Texas law. If this Policy is renewed, the Premium for a subsequent Policy Year may change. Any Premium increase will become effective only upon renewal and will be communicated as required by applicable federal and Texas law. Please see Section IX – Renewal, Continuation, Nonrenewal, and Termination for additional information.

Please read Your contract carefully. 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, CEO

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SECTION I – INTRODUCTION

This document is Your Policy which outlines Your benefits, coverage details, Exclusions, and termination provisions under the Plan. Your Policy should be read together with Your Schedule of Benefits to understand the health benefits available to You under Your Plan.

Important: This Plan provides coverage for Basic Health Care Services as required under Texas law. However, please note that legally permissible restrictions, such as visit limits or the need for Prior Authorization, may still apply to certain services.

The Policy 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
- Copayments, and Cost Share Percentage payments required when You receive Covered Services.

Please carefully read and review the entire Policy. 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 Policy. These definitions will help assist You in understanding concepts, terminology, and meanings within the Policy.

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 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	[1460 Broadway New York, NY 10036]	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.

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 Policy

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

Many of the sections of this Policy 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 Policy and any future Riders/Enhancements or Amendments at antidotehealth.com/plandocs or antidotehealth.com/member or request printed copies by contacting Member Services. Antidote will mail a written copy of Your Policy within seven (7) business days of Your request.

Because this Policy 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 Policy, You should read the entire document and pay particular attention to Section V – Covered Health Care Services, and Section VI – Exclusions and Limitations.

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

Please call Us if You have questions about the Covered Services available to You. If there is a conflict between this Policy 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 Policy, and they are not responsible for knowing or communicating Your benefits.

Defined Terms

Because this Policy is part of a legal document, it is important that You understand the information it contains. Certain capitalized words within this Policy 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 Policy. 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 Policy, 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.

Your Plan may also include access to virtual visits with Antidote clinicians who can provide primary care services, including routine, wellness, preventive, and chronic care. These clinicians can serve as a primary point of contact for Your care and can help coordinate services and connect You to In-Network Providers when appropriate. Accessing care through Antidote offers You the opportunity to reduce Your out-of-pocket expenses. To confirm if Your Plan includes coverage for Covered Services rendered by Antidote's virtual Providers, review your Summary of Benefits and Your Telehealth Care Benefit Rider, if applicable. More information about the Antidote Virtual Providers is available at antidotehealth.com.

In addition, 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.

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. Call the Provider's office if You want to make an appointment. If You need help, call Member Services at the toll-free number on Your ID Card. We will help You make the appointment.

Identification (ID) Card

When You 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

Acquired Brain Injury: a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The Injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

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 Investigational treatments;
    - A determination of an individual's eligibility for benefits under the Plan;
    - A determination that a health care service is not a covered benefit;
    - The imposition of an Exclusion, including Exclusions for source of Injury, Network, or any other limitation on benefits that would otherwise be covered.
- 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.

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: A neurobiological disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder. A neurobiological disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

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

Basic Health Care Services (BHCS): Health care services that are mandated at the state-level by the Department of Insurance (TDI) and the Texas Legislature. The Insurance Commissioner determines the services an enrolled population might reasonably need to be maintained in good health and enforces compliance.

Benchmark Rate: The median rate used to determine payment for the same or similar service in the same geographic area. The Benchmark Rate is used for payment of Out-of-Network claims for emergency care provided by an Out-of-Network provider or facility and for care received by the Covered Person from an Out-of-Network provider (such as an anesthesiologist, radiologist or pathologist) at a Network Provider.

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.

Cochlear Implant: An FDA-approved, implantable electronic medical device designed to provide a sense of sound to a Covered Person with severe to profound sensorineural hearing loss. Unlike a hearing aid that amplifies sound, a Cochlear Implant bypasses the damaged portions of the inner ear (cochlea) to directly stimulate the auditory nerve.

For the purposes of this Plan, the term includes both the surgically implanted internal component and the external speech processor and controller.

Complications of Pregnancy: Conditions requiring Hospital confinement when the pregnancy is not terminated, whose diagnoses are separate medical conditions from pregnancy but are worsened by pregnancy or caused by pregnancy. Examples include Acute nephritis, nephrosis, cardiac decompensation, missed abortion, and other similar medical or surgical conditions of comparable severity. This does not include false labor, occasional spotting, Physician-prescribed rest during pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia or other conditions associated with the management of a difficult pregnancy that are considered normal pregnancy related complications.

Continuity of Care: The right of a Member to continue receiving an ongoing course of treatment from a treating Network Provider whose participation in the Plan terminates (for reasons other than medical competence or professional behavior). This right applies when the Member has a Special Circumstance, which is a condition where the treating Provider reasonably believes that discontinuing care could cause harm to the Member. Examples of a Special Circumstance include, but are not limited to, an acute condition, a disability, a life-threatening illness, or a pregnancy that is past the 24th week.

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. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.

Cost Share Percentage: A specific percentage of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which You must pay. See the Schedule of Benefits for any exceptions. Your Cost Share Percentage 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.

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

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.

Craniofacial Abnormality: is a congenital or developmental abnormality of the head or face, including a cleft lip or palate.

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.

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. Coverage will begin at 12:01 a.m. on the Effective Date and end at 11:59 p.m. on the applicable termination date in the time zone where You live.

Emergency Medical Condition: A medical condition that manifests itself by such Acute symptoms of recent onset 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 individual's health in serious jeopardy;
- Serious impairment to bodily function of the individual;
- Serious dysfunction of any bodily organ or part of the individual;
- Serious disfigurement; Or
- With respect to a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Services: Those health care services that must be available on a seven-days-per-week, twenty-four-hours-per-day basis to evaluate and 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.

Episode of Care: The complete set of services delivered to a Covered Person for a specific medical condition or procedure, from the start of treatment until its conclusion.

Essential Health Benefits (EHB): The federal-level mandate of the broad category of health care services created by the Affordable Care Act.

Exclusive Provider Organization / EPO Plan: A type of health benefit plan that provides coverage for Covered Services only when those services are received from Network Providers. Except for Emergency Care, or in limited circumstances where a Covered Services is Medically Necessary and cannot be reasonably provided by a Network Provider and has been authorized by US in advance, any services received from out-of-network Providers are not covered, and the Member will be solely responsible for the full cost of those services.

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

Experimental/Investigational: 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/pharma 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, non-implantable instrument or device designed, manufactured, or offered for the purpose of aiding or compensating for impaired human hearing, including all attachments, accessories, and parts thereof, except batteries,

cords, and receivers. The device must be Medically Necessary and prescribed and dispensed by a licensed audiologist, a licensed hearing aid dealer or fitter, or an otolaryngologist following a clinical hearing evaluation. This definition does not include Cochlear Implants, bone-anchored hearing aids (BAHAs), or over the counter (hearing devices).

Hold Harmless: Protections from a Network Provider seeking payment from a Covered Person for Medically Necessary services covered by Antidote.

Home Health Care: A range of skilled and therapeutic Home Health Care is a range of skilled services You receive in Your home from a home and community support services agency that must be licensed under the Texas Health and Safety Code. These services are provided to help You recover from an illness or Injury. To be covered, services must be part-time or intermittent, not long-term. Covered Services include skilled nursing, physical therapy, occupational therapy, speech therapy, and medical social work. This benefit also includes related medical supplies and equipment, but it does not cover prescription drugs. Please note that all Home Health Care Services require Prior Authorization. The provider arranging Your care is responsible for obtaining this approval from the Plan before Your services begin.

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.

Injury: Accidental bodily harm which is sustained by the Covered Person and which is the direct and sole result of an accident, independent of disease or bodily infirmity.

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 state law.

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

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

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

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

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

Out-of-Pocket: The most You pay during a Benefit Period in Cost-Sharing (as listed on Your Schedule of Benefits) before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium or the cost of health care services We do not cover.

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

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

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

Physician-Administered Drug: An Outpatient Drug other than a vaccine that is typically administered by a Health Care Provider in a Physician's office or other Outpatient clinical setting. For example, Drugs that are infused or injected are typically Physician-Administered Drugs. Physician-Administered Drugs may require Prior Authorization. Antidote may perform clinical review of the requested site of care, treatment setting, and available treatment alternatives. Where appropriate, Antidote may refer the Covered Person for care management or other clinical support services.

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.

Policy: refers to this Policy 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 Policy provides a summary of the terms of Your benefits. Policy may also be referred to as "Plan".

Policyholder: The person to whom this Plan is issued. The Policyholder is legally responsible for the payment of Premium and any Copayments and Cost Share Percentages 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 to treat a Covered Person for a chronic, disabling or life-threatening illness, 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.

Primary Care Provider (PCP): A Physician who is a Network Provider and generally include family practitioners, general practitioners, internists, pediatricians, and obstetricians/gynecologists (OB/GYNs).

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

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; Hospice; Home Health Care Agency; a comprehensive care center for eating disorders pursuant to state law.
- **Health Care Provider** – A licensed Hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under any applicable law, including a Physician, podiatrist, optometrist, Psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dietitian, dentist, pharmacist or an individual accredited or certified to provide Behavioral Health Care Services.
- **Home Health Care Agency** – A facility, licensed by the Texas Health and Human Services Commission (HHSC) under Chapter 142, Health and Safety Code, 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/find-a-doctor or upon Your request to Us. The list will be revised from time to time by Us.
    - Antidote's In-Network lab Providers consist of lab Providers that have demonstrated high standards for access, quality, cost, data, and service based on proprietary criteria. We will only pay for lab work conducted by an In-Network lab Provider, unless conducted in the event of an emergency.
- **Out-of-Network Provider** – A Provider who doesn't have a contract with Us to provide services to You. The services of Out-of-Network Providers are covered only for Emergency Services or when authorized by Us.
- **Outpatient Psychiatric Facility** – A facility which mainly provides Diagnostic and therapeutic services for the treatment of Mental Health Conditions or Substance Use on an Outpatient basis.
- **Pharmacy** – An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order.
- **Physician** – Means a doctor of medicine; doctor of osteopathy; doctor of dental surgery or of dental medicine; doctor of podiatric medicine; or doctor of optometry who is legally authorized to practice medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, or optometry by the State in which they perform such function and who is acting within the scope of their license when they perform such functions.
- **Primary Care Physician/Primary Care Provider (PCP)** – A Network Physician or Provider who has been selected by the Member to provide initial and primary care, maintain the continuity of patient care, and who may initiate Referrals for care.

- **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 (legally referred to as a "Nursing Facility") constituted, licensed, and operated as set forth in applicable Texas law, which:
    - mainly provides Inpatient care and treatment for persons who are recovering from an illness or Injury;
    - provides organized and structured nursing care and services;
    - provides care supervised by a Physician;
    - provides twenty-four (24) hour per day nursing services that are sufficient to meet the needs of all residents, provided or supervised by a licensed nurse;
    - maintains a daily medical record for each patient;
    - provides access to specialized rehabilitative services such as physical, occupational, and speech-language therapy for residents who require them;
    - 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**
- **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.

Referral: A directive or request by a Network Physician or Provider for a Member to receive clinical evaluation, consultation, or treatment from another physician or provider.

- In-Network Referrals: These represent clinical recommendations from one physician to another. Under this EPO Plan, You ***do not*** need an administrative Referral from a Primary Care Provider (PCP) to seek care from a Network Specialist

- Out-of-Network Referrals (Network Gaps): If a covered, Medically Necessary service is not available within Our Network, We may authorize a Referral to an Out-of-Network provider. When approved by Us in advance, this Out-of-Network Referral ensures that the authorized services are covered at the In-Network Cost-Sharing rate, protecting You from Balance Billing as required by Texas law.

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

Residential Treatment: Treatment of Mental Health Conditions and/or Substance Use provided in a Hospital or treatment facility licensed to provide a continuous, structured program of treatment and rehabilitation, including twenty-four (24) hour-a-day nursing care.

Individualized and intensive treatment includes observation and assessment by a Psychiatrist at least weekly and rehabilitation, therapy, education, and recreational or social activities.
Residential Treatment Centers are only covered when qualified as a mental health facility or Substance Use facility providing continuous, structured, twenty-four (24) hour-a-day program of mental health, Drug or alcohol treatment and rehabilitation including twenty-four (24) hour-a-day nursing care.

Routine Patient Care Costs: Costs associated with the provision of a Medically Necessary health care service or supply that is typically provided for a Covered Person who is not enrolled in a clinical trial; and costs associated with the provision of a Medically Necessary drug, device, biological product, or service that is being investigated in a clinical trial, to the extent that the drug, device, biological product, or

service is provided to the Covered Person for a serious or life-threatening condition and is otherwise covered under the health benefit Plan.

Routine Patient Care Costs do not include the costs associated with the provision of an Investigational drug, device, biological product, or service; the costs of services that are not health care services; or any costs paid for by the sponsor of the clinical trial.

Schedule of Benefits: A document, incorporated by reference in this Plan that describes the Copayments, Cost Share Percentage, Out-of-Pocket, Prior Authorization requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of Texas, 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.

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

Therapeutic Abortion: an abortion performed because of a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that places the mother at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed or induced.

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.

Urgent Care: Those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill

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

Usual and Customary Charge: A reasonable charge for a service or supply which is the lesser of:

- the individual provider's usual charge for the service or supply;
- the provider's usual charge for a similar service or supply; or
- the usual charge of most providers of similar services or supplies in the same geographic area.

Application of the Usual and Customary Charge is limited to non-emergency, out-of-network services where the Covered Person knowingly chooses to see an out-of-network provider. Note: Use of an out-of-network provider will result in a denial of payment in the absence of extenuating circumstances.

Utilization Review ("UR"): A system for prospective, concurrent, or retrospective review of the Medical Necessity and appropriateness of Health Care Services and a system for prospective, concurrent, or retrospective review to determine whether Health Care Services are Experimental or Investigational. Utilization Review does not include a review in response to an elective request 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 condition, regardless of cost or benefit coverage.
- To voice complaints or appeals about the organization or the care it provides.
- To make recommendations regarding the Antidote'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 choose any Network Provider for Your health care needs and to receive information on Network Providers close to Your home or work. As an EPO Member, You are not required to select a primary care provider and do not need a Referral to see a Network Specialist.
- To know the name and job title of people providing care to You.
- To a second opinion by a Network Provider 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, Network Providers, advance directive information, 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 Providers to understand Your wishes about 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 take an active role in Your health care. While You are not assigned a primary care provider in an EPO, You are encouraged to choose and establish a relationship with a Network Provider to help manage and coordinate Your care.
- 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 by calling Your Network 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, 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.

You are protected under Texas Hold Harmless provisions from being billed by Network Providers for Covered Services. A Network Provider may not bill You, charge You a deposit, or attempt to collect payment from You for any Covered Service except for Your specific cost-sharing amounts (i.e., Your Copayment or Coinsurance).

As a Covered Person in the Antidote plan, You are protected from being billed for Covered Services by any of our Network Providers. This is a fundamental protection of your membership, often called the "Hold Harmless" rule. It means that Network Providers have a contract with Us to accept Our payment, plus your required cost-sharing (Copayment or Coinsurance), as payment in full.

The purpose of this rule is to keep you out of the middle of any financial disagreements between Us and our Network Providers. For example, if We are slow to pay a claim or have a dispute with a Network Provider about the correct payment amount for a Covered Service, the Network Provider cannot bill you for that money. Even in the rare event that Antidote were to have financial problems or go out of business, this protection remains in place.

However, this powerful protection comes with an important responsibility for You as a Covered Person: it only applies when you follow the Antidote's rules. The Hold Harmless protection does not apply if a service is not covered because of your failure to follow the Antidote's requirements. This includes situations where you fail to get a required Prior Authorization, choose to see an Out-of-Network provider for a non-emergency, or receive a service that is a specific Exclusion from Your benefits.

If you ever receive a bill from a Network Provider that You believe is incorrect, do not pay it. Contact Member Services immediately for assistance.

This following table summarizes when You are and are not protected from being billed by a Network Provider for more than your standard cost-sharing.

Summary of Your Billing Protections		
Scenario	**Are You Protected by the Hold Harmless Rule?**	**Explanation**
Antidote is slow to pay or makes a processing error.	Yes	The Network Provider's agreement requires them to work with Us to resolve administrative issues. You are kept out of the middle.
Antidote and the Network Provider disagree on the payment amount for a Covered Service.	Yes	This is a business dispute between Antidote and the Network Provider. The Network Provider cannot bill you for the disputed amount.
Antidote goes out of business and cannot pay its claims.	Yes	The Network Provider cannot bill you if Antidote goes out of business and cannot pay Your claims.
You did not get a required Prior Authorization before receiving care.	No	Your failure to follow Antidote's Prior Authorization rules makes the service not covered. You may be responsible for the full cost of the service.
You chose to see an Out-of-Network provider for a routine (non-emergency) service.	No	The Hold Harmless protection only applies to providers who are Network Providers. You are responsible for the full cost of out-of-network care.
You received a service that is a specific Exclusion in your Antidote plan (e.g., cosmetic surgery).	No	The Hold Harmless rule only applies to Covered Services. You are responsible for the cost of services that are covered under Your benefits.

Specialists

A wide range of Specialists are included in the Antidote Network. As a Member of this EPO Plan, You do not need a Referral from a primary care provider or any other provider to seek care from any Specialist within Our Network. Note that while a Referral is not required to schedule an appointment with a Network Specialist, certain services, procedures, or treatments recommended by the Specialist may still require Prior Authorization from the Plan before they are covered. Additionally, because this is an EPO Plan, You must use Network Providers for Your Care to be covered, except in the case of a Medical Emergency.

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 may be provided when You use Out-of-Network Providers. Contact Us at the toll-free number on Your ID Card to request the necessary approval and Prior Authorization for out-of-network services in this situation.

Emergency Services and Post-Stabilization Care

Antidote covers Emergency Services 24 hours a day, seven days a week, regardless of whether You receive care from a Network Provider or Out-of-Network Provider. An Emergency Medical Condition is defined by the "prudent layperson" standard, which means a condition with symptoms so severe (including severe pain) that a person with an average knowledge of health and medicine would reasonably expect that failing to get immediate medical attention could place their health in serious jeopardy, lead to serious impairment of bodily functions, or result in serious disfigurement. This coverage applies whether you are treated in or outside the Service Area.

For any emergency screening and the treatment necessary to Stabilize Your condition, You will only be responsible for Your standard in-network cost-sharing (Copayment and Coinsurance). You are protected from any additional Balance Billing from the provider for these emergency services.

Care After Your Condition is Stabilized

Once your Emergency Medical Condition is stabilized, the rules for coverage change, especially if You are at an Out-of-Network Hospital. Stabilization means you can be safely transferred to another facility without a material deterioration of Your condition.

- **The Out-of-Network Provider's Responsibility**: Texas law requires the Out-of-Network Provider or facility to contact Us for authorization to provide any further care after You are stable. They must make this notification no later than the **next business day** after you are admitted.
- **Our Responsibility After Notification**: Once We are notified, We will work with the facility to either authorize continued care there or arrange and pay for a safe and timely transfer to a Network Provider or Hospital where You can continue to receive covered care.

- **IMPORTANT – When a Provider Fails to Notify Us**: If the Out-of-Network Provider fails to contact Us for authorization as required by law, any post-stabilization services you receive at that facility will be considered unauthorized and are not Covered Services under your Antidote plan. In this specific situation, the standard Hold Harmless protection does not apply, and the Out-of-Network Provider may bill You for the full cost of those unauthorized services.
- **IMPORTANT** – **If You Refuse Transfer to a Network Provider**: Following Stabilization, You become financially responsible for all subsequent charges at the Out-of-Network hospital. If You refuse transfer, Our case manager or the Out-of-Network hospital may ask You to sign a Financial Responsibility Waiver or Refusal of Transfer form. This document explicitly states that Antidote arranged a transfer to a Network Provider, You are reusing the transfer and You understand that by refusing, You are choosing to receive care on an Out-of-Network basis and have accepted personal and full responsibility for the Out-of-Network hospital's billed charges from the point of notification forward.
- **IMPORTANT** – **If You Refuse Sign the Waiver or Transfer Form:** Your refusal to transfer shifts financial responsibility. The refusal to sign the Financial Responsibility Waiver or Refusal of Transfer form does not negate the refusal of transfer; it is simply a refusal to acknowledge it in writing.

The following chart summarizes how We address emergency care and post Stabilization:

Phase of Care	Provider	Member's Financial Responsibility	Is Member "Held Harmless" from Balance Billing?
Emergency & Stabilization	Out-of-Network	In-Network Cost-Sharing Only	Yes
Post Stabilization - Out-of-Network Provider notifies Antidote and gets an authorization	Out-of-Network	In-Network Cost-Sharing Only	Yes, if Antidote has authorized the care
Post Stabilization - Out-of-Network Provider fails to notify Antidote or You refuse to transfer to a Network Provider	Out-of-Network	Potentially the full billed charges.	No, service becomes unauthorized and non-covered

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 the timeframe specified above.

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.

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 and Cost Share Percentage. 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/find-a-doctor.

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 that You received such 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, in addition to any applicable Copayment and Cost Share Percentage. Any applicable Copayment and Cost Share Percentage 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.

As specified previously, Texas law together with the Federal No Surprises Act protects you from surprise medical bills. For emergency care, or for care you receive from an Out-of-Network Physician at a Network Hospital, you are only responsible for your normal in-network cost-sharing. These providers cannot Balance Bill you for any additional amount unless You knowingly choose to waive this protection in writing beforehand.

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

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

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

When We send You to an Out-of-Network Provider for Prior Authorized care because no Network Providers are available, We will also:

- Cover the service at the same level as if You had used a Network Provider. You will not be limited by Your Service Area for this care;
- Advise You that You can ask Us to recommend an Out-of-Network Provider who agrees not to bill You more than Your normal Cost-Share. We will also tell You to contact Us right away if You receive a Balance Bill;
- Explain that You may choose another Out-of-Network Provider, but if You do, that provider may bill You for any amount above Our Usual and Customary Rate; and
- Provide, upon request, the amount of Our Usual and Customary Rate for the anticipated services.

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

If You receive a Balance Bill, please contact Us at 888-623-3195.

Utilization Review Decisions, Timeframes and Procedures

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

- Urgent Care (Expedited) Decisions:
  - Threat to Covered Person: Where the application of the regular timeframe for a Medical Necessity determination could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function.
  - Turnaround Time: The Plan must decide and provide notification no later than one (1) business day after receiving the request for service.
- Standard Pre-Service Decisions (Non-Urgent Prior Authorization):
  - Threat to Covered Person Services that do not meet the definition of Urgent Care. These are typically elective procedures, planned admissions, or expensive therapies that require approval before the service is rendered.
  - Turnaround Time: The Plan must decide and provide notification no later than three (3) business days after receiving the request for service.
- Concurrent Review Decisions (During a Hospital Stay):
  - Threat to Covered Person: Decisions regarding continued Hospitalization or continued services during an ongoing course of treatment.
  - Turnaround Time: The Plan must decide and provide notification no later than one (1) business day after receiving the request for review.
- Retrospective Review Decisions (After Services Have Been Rendered):
  - Threat to Covered Person: These are for services that have already been provided, and the determination is for payment. While there's no immediate health threat, timely payment is important.
  - Turnaround Time: The health plan must decide and provide notification no later than thirty (30) days after receiving the request for payment.

Designation of an Authorized Representative

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

Prior Authorization for Inpatient and Outpatient Services

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

Your Provider, if they ask, a list of services that require Prior Authorization within 5 business days.

For most Prior Authorization requests, We will review the request and give a decision within 3 calendar days after We receive it. If the request involves an upcoming hospital stay, We will include the number of days We approve for the stay based on your doctor's recommendation and Our medical guidelines. If You are already in the hospital when Your Provider makes the request, We will give a decision within 24 hours.

If Your Provider needs to renew a Prior Authorization that is about to expire, they can ask for a renewal at least 60 days before it expires. If We receive their request before the expiration date, we will review it and, if possible, make a decision before the current authorization ends.

Prior Authorization Exemption for Certain Physicians and Providers

Some Providers qualify for a Prior Authorization "Gold Card" exemption based on how often their requests are approved by Us. If a Provider qualifies for an exemption under Texas law, We cannot require Prior Authorization for the service for which the Provider is exempt. This exemption remains in effect for as long as the Provider meets the standard of care for the specific service. Your Provider does not need to apply for this exemption; it is determined automatically. Texas Insurance Code, Chapter 4201, Subchapter N

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

Your Financial Responsibility for Prior Authorization

As a Covered Person in an Antidote Plan, you are protected by the "Hold Harmless" rule. This rule means that Our Network Providers cannot bill You for Covered Services beyond Your standard cost-sharing (Copayment or Coinsurance). We want to be very clear, however, about how this protection works in relation to Prior Authorization.

Prior Authorization is a condition required for certain services to be considered "Covered Services."

It is Your responsibility, often working with Your Network Provider, to ensure Prior Authorization is obtained from Us before You receive services that require it. The "Gold Card" exemption may remove this requirement for certain Network Providers and services, but it does not remove the requirement for all services.

If Your Network Provider fails to obtain a required Prior Authorization (and no "Gold Card" exemption applies), the service You received will be considered unauthorized and therefore is not a Covered Service. Because the Hold Harmless rule only protects You from being billed for Covered Services, this protection will not apply. You will be financially responsible for the entire cost of the unauthorized service.

This is different from a payment dispute. If Prior Authorization was obtained but We have a disagreement with the provider about the payment amount, You are held harmless. The key distinction is whether the service was authorized and covered in the first place.

For Your own financial protection, it is critical that You and Your Network Provider verify with Us that an authorization is in place before You receive care.

When Are You Held Harmless by a Network Provider

This table clarifies when the Hold Harmless protection does and does not apply.

Scenario	Is the Service Considered "Covered"?	Are You Protected from Being Billed Beyond Your Cost-Sharing?
Prior Authorization was obtained but Antidote and the provider disagree on the payment amount.	Yes	Yes. This is a business dispute, and the Hold Harmless rule fully protects you.
The Plan is slow to pay a claim for a Covered Service.	Yes	Yes. You are protected from billing related to administrative delays.
A required Prior Authorization was NOT obtained before the service was provided.	No	No. You are NOT protected. Because the service is not "Covered," the provider has the right to bill you for the full amount.
The provider has a "Gold Card" exemption, so no Prior Authorization was required.	Yes	Yes. The service is considered authorized and therefore "Covered." You are protected.

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

Please note that emergency admissions may be reviewed post admission.

To obtain Prior Authorization or verify requirements for Inpatient or Outpatient Services, including which services require Prior Authorization, You or Your Provider can call Antidote at the toll-free number on Your ID Card or online at antidotehealth.com/provider.

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

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

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

Administrative Denials and Retrospective Reviews

There are different reasons a claim may be denied after You have received care, and the reason for the denial determines the review process that follows. The two main types of review are administrative and retrospective.

Administrative Denials for Failure to Obtain Prior Authorization

Your benefits require that You or Your Network Provider obtain Prior Authorization from Us before You receive certain services. If Your Network Provider fails to obtain the required Prior Authorization for a service (and no "Gold Card" exemption applies), the claim for that service will be denied.

- This is called an administrative denial. The denial is based on the failure to follow the Plan's required procedures, not on a judgment of whether the care was Medically Necessary.
- In the case of an administrative denial for lack of Prior Authorization, the Plan is not required to perform a retrospective review of Medical Necessity. The failure to obtain Prior Authorization is, in itself, sufficient reason for the denial, and You will be held financially responsible for the full cost of the service.

Retrospective Review of Medical Necessity

A formal "retrospective review" occurs when We review the Medical Necessity of care after it has already been provided. This process is governed by specific state regulations and is used in a different situation.

- A retrospective review is typically performed when no Prior Authorization was required for the service, but We need to determine if the care you received met the Plan's criteria for Medical Necessity based on the medical records submitted by your Network Provider.
- In this scenario, We must decide within 30 days of receiving all necessary information. Any denial must be made by a qualified physician.

It is important to understand that this formal retrospective review process does not apply to cases where a required Prior Authorization was simply missed.

This table clarifies the different processes and outcomes.

Scenario	Network Provider's Action	Antidote's Obligation	Governing Regulation
Prior Authorization was required, but Network Provider failed to obtain it	Submits claim	Issue an administrative denial. The Plan is not required to perform a retrospective Medical Necessity review.	Standard plan provisions and general Utilization Review rules.
No Prior Authorization was required for the service	Submits claim	Pay the claim, or if Medical Necessity is questioned by the Plan, perform a formal retrospective review within 30 days	TIC Chapter 4201 and 28 TAC Chapter 19, Subchapter T

To request a Retrospective Review, You may call Antidote at [888-623-3195].

Your In-Network Provider may also request a Retrospective Review by calling [888-509-2688].

Step Therapy for Medications

For certain medical conditions, the Plan uses a process called Step Therapy to help ensure You receive safe, effective, and affordable treatment. This process may apply to some drugs covered under Your medical benefit, such as medications administered in a doctor's office or clinic.

Step Therapy means We may require You to first try a preferred, clinically effective medication for Your condition before We will cover a different, non-preferred medication. These preferred medications are often proven to be safe and effective for most patients and can be more affordable.

Your Right to a Step Therapy Exception in Texas

While Step Therapy is a common practice, Texas law provides important patient protections through a clear and timely exception process. Your provider can request an exception to our Step Therapy requirement on Your behalf, and under state law, We must grant this exception if Your provider confirms that one of the following is true:

- The preferred drug We require You to try is contraindicated or would likely cause you harm.
- You have already tried the preferred drug (or another drug in the same class) and it was not effective or caused an adverse reaction.
- You are already stable on a medication prescribed by Your previous health plan, and switching could destabilize Your medical condition.
- The preferred drug is not expected to be effective based on Your medical history or clinical characteristics.
- The required Prescription Drug is not in Your best interest because it is expected to create a barrier to adherence to the treatment plan, will likely worsen a comorbid condition, or will likely decrease Your ability to achieve or maintain reasonable functional ability in performing daily activities.

This exception process and these specific criteria are required by the Texas state law.

Timelines for an Exception Request

Texas law also sets strict deadlines for Us to respond to a Step Therapy exception request from Your Network Provider.

- For urgent situations, We must respond within 24 hours.
- For all other standard requests, We must respond within 72 hours.

If We fail to respond within these legal timeframes, the exception is automatically granted. If Your request for an exception is denied, you have the right to appeal that decision.

Adverse Determination

A written notification of an Adverse Determination will include the principal reason or reasons for the determination, the instructions for initiating an appeal, 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 certification of an admission, procedure, or service.

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

Case Management

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

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

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

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

- Hypertension;
- Diabetes; and
- Mental Health.

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

We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your Authorized Representative in writing.

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by Antidote. Charges for services and supplies which Antidote determines are not Medically Necessary may not 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/Investigational 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 Plan for Your right to an Appeal and independent review of Our determination that a service is not Medically Necessary.

Identification Card

The Identification Card should be shared with Providers to allow them to verify Your eligibility and to identify covered benefits under Your Antidote Plan. The ID Card offers a convenient way of providing important information specific to Your coverage including, but not limited to, the following:

- Your Member ID.

- Important telephone numbers.

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

Telemedicine

Your coverage will include Telemedicine visit services provided by designated Network Providers. Benefits for these services are provided to the same extent as an in-person service under any applicable benefit category in this section unless otherwise specified in the Schedule of Benefits. Coverage will not be denied solely because the originating site or distant site is located outside Texas, provided the requirements of applicable Texas law are satisfied.

See Your Schedule of Benefits for any applicable Cost Share Percentage, Copayment and Benefit Limitation information.

Continuity of Care

Continuity of Care is a critical protection required by federal and Texas law that allows You to continue receiving treatment for a limited time with a provider who is not, or is no longer, in Our Network. The purpose of this protection is to ensure Your care is not disrupted during a period of transition, giving You time to safely move to a Network Provider.

This protection applies in two situations:

- When Your Provider Leaves Our Network (Continuity of Care): If you are an existing Covered Person and your current treating provider terminates their contract with Antidote.
- When You Are a New Member of Our Plan (Transitional Care): If You recently joined the Plan and Your current provider is not in Our Network. This is commonly referred to as Transition of Care.

Continuity of Care Eligibility

This protection is not automatic and is reserved for Covered Persons who are considered "Continuing Care Patients" or have a "Special Circumstance" under state and federal law. You are eligible to request Continuity of Care if you are undergoing an Active Course of Treatment for specific, significant medical conditions, including:

- An Acute or Serious and Complex Condition: A condition serious enough that a change of providers could lead to a relapse or complication.

- Duration: The Plan will continue to cover treatment up to ninety (90) days from the date You are notified of the provider's termination, or until the course of treatment is complete, whichever is shorter.

- A Chronic Condition: A life-threatening, degenerative, or disabling disease or condition.
  - Duration: The Plan will continue to cover treatment up to 90 days from the date You are notified of the provider's termination, or until the course of treatment is complete, whichever is shorter.

- A Pregnancy: If You are undergoing a course of obstetrical treatment, including if You are past the 24th week of pregnancy.
  - Duration: The Plan will continue to cover treatment by the terminated provider through the completion of your postpartum period.

- A Terminal Illness: An advanced, incurable, or irreversible medical condition that has a high probability of causing death within six (6) months or less. Examples of terminal illnesses include, but are not limited to, metastatic (Stage IV) cancer, end-stage renal (kidney) disease, advanced congestive heart failure (Class IV), or advanced Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's disease).
  - Duration: The Plan will continue to cover treatment by the terminated provider for a period of up to nine (9) months from the effective date of the termination.

- Institutional Care or Non-Elective Surgery: If You are undergoing a course of institutional or inpatient care, or are scheduled to undergo non-elective surgery (including post-operative care).
  - Duration: Up to ninety (90) days from the date You are notified of the provider's termination.

Continuity of Care Protections

If your request for Continuity of Care is approved, you are guaranteed two important protections:

- Full Financial Protection: During the approved period, We will treat the services from the Out-of-Network Provider as if they were delivered by an In-Network Provider. You will only be responsible for Your normal In-Network Cost-Sharing (Copayment and Coinsurance). The provider is prohibited from Balance Billing You for any additional amounts.

How to Request Continuity of Care

Continuity of Care is not automatic. If You believe You qualify, You or Your provider must contact Member Services to formally request this protection. We will review Your request based on your medical condition and the eligibility criteria established by state and federal law.

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

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, or the available Network Providers are not accessible within a reasonable time or distance as defined by Texas standards, We will approve an authorization to an appropriate Out-of-Network Provider. The Plan is then required to negotiate a Single Case Agreement (SCA) with the Out-of-Network Provider for that specific Episode of Care. Through the SCA, the Out-of-Network Provider agrees to accept the Plan's payment plus the Covered Person's standard In-Network cost-sharing as payment in full and You are protected from Balance Billing. 28 Texas Administrative Code § 11.1607

If the Out-of-Network Provider refuses to sign an SCA, the Plan will issue an authorization for the Medically Necessary services and the Plan will inform You that the Out-of-Network Provider has refused to sign an SCA and that You are only responsible for Your In-Network cost sharing. Do not pay any bill from the Out-of-Network Provider beyond Your In-Network cost sharing and contact the Plan immediately. The Plan will also notify the Out-of-Network Provider that the services were authorized, the payment amount for such service(s), and remind the Out-of-Network Provider that You should be held harmless from any amounts beyond your In-Network cost sharing.

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

Accidental Dental

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

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

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

Acquired Brain Injury

Benefits for eligible expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other medical condition. Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation; Neurobehavioral, Neuropsychological, Neurophysiological and Psychophysiological Testing and Treatment; Neurofeedback Therapy, Remediation, Post-Acute Transition Services and Community Reintegration Services, including Outpatient Day Treatment Services, or any other Post-Acute Treatment Services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury.

The primary goal of the treatment for an Acquired Brain Injury is to improve or restore function and may be provided at a Hospital, an Acute or post-Acute Rehabilitation Hospital, an assisted living facility or any other Facility at which appropriate licensed, skilled services or therapies may be provided.

To ensure that appropriate post-Acute care treatment is provided, this Plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

- has incurred an Acquired Brain Injury;
- has been unresponsive to treatment; and
- becomes responsive to treatment at a later date.

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

Acquired Brain Injury care does not include Custodial Service or Care.

Ambulance Services

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

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

Autism Spectrum Disorder

Generally recognized services prescribed by a Provider in a treatment plan for Autism Spectrum Disorder are covered when the Covered Person was diagnosed before the Covered Person's 10th birthday. Covered Services may include evaluation and assessment, applied behavior analysis (ABA), behavior training and management, speech therapy, occupational therapy, physical therapy, and certain medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder. Covered Services are subject to Medical Necessity and may require Prior Authorization.

Individuals providing treatment prescribed under this Plan must be a health care practitioner:

- who is licensed, certified, or registered by an appropriate agency of the state of Texas;
- whose professional credential is recognized and accepted by an appropriate agency of the United States; or
- who is certified as a Provider under the TRICARE military health system.

Benefits for Autism Spectrum Disorder will not apply towards the therapy limitations indicated on your Schedule of Benefits.

After the Dependent Child reaches the age of ten, Covered Services for Autism Spectrum Disorder continue to be available as otherwise covered under this Plan. All contractual provisions apply, including defined terms, Medical Necessity, Prior Authorization, limitations, and Exclusions.

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

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

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 Programs are not limited by state-mandated minimum hours or days of treatment. Instead, these services must comply with generally accepted behavioral health standards of care, including the American Society of Addiction Medicine (ASAM) Criteria or other evidence-based clinical guidelines, as required under Texas Utilization Review regulations. The services may address Substance Use, mental or behavioral health issues, or both, which are dual diagnosis programs. These programs are usually used as a step down from Acute Inpatient care, residential care, or a Partial Hospitalization program. They may also be viewed as a step up from regular Outpatient Services.

Other Outpatient Services. The Plan provides benefits for office-based Behavioral Health Care Services. These include Diagnostic evaluation, screening, testing and assessments, counseling, individual psychotherapy, group psychotherapy, family psychotherapy, psychiatry, and crisis services. The services may be provided by a licensed mental health professional.

Coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations, including Copayments and Cost Share Percentage provisions that are less favorable than the limitations that apply to a physical sickness as covered under this Policy.

Biomarker Testing

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

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

Key Definitions

- Biomarker: A measurable characteristic used to indicate normal or abnormal biological processes, disease conditions, or responses to treatment. This includes gene mutations or protein levels.
- Biomarker Testing: Analyzing a patient's tissue, blood, or other samples to find biomarkers. This can include single tests, multiple tests in a panel, or whole genome sequencing.
- Clinical Utility: Means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.
- Consensus Statements: Recommendations made by an independent panel of experts, based on the best available evidence, to improve clinical care. These are developed using clear, transparent methods and include policies to manage conflicts of interest.
- Nationally Recognized Clinical Practice Guidelines: Evidence-based guidelines developed by independent organizations or medical societies. They set standards of care based on a thorough review of evidence and consider the benefits and costs of different care options to optimize patient care.

Biomarker testing requires Prior Authorization. See Section XI for further information regarding requesting pre-service approval for biomarker testing. If a specific biomarker test is excluded from coverage, You or Your Authorized Representative may request an exception. To make a request, contact Us in writing or call the toll-free number on Your ID Card. We will notify You of Our determination within seventy-two (72) hours.

Chiropractic and Osteopathic Services

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

Clinical Trials

Benefits are available under the Plan for services for Routine Patient Care Costs that are Medically Necessary and rendered as part of an approved clinical trial if the services are otherwise Covered Services under this Plan. Cost Share Percentage, and other Cost-Sharing requirements apply to all benefits provided in connection with a clinical trial.

Approved clinical trial means:

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

- Specific goals.
- A rationale and background for the study.
- Criteria for patient selection.
- Specific directions for administering therapy and monitoring patients.
- A definition of quantitative measures for determining treatment response.
- Methods for documenting and treating adverse reactions.
- The treatment is being provided as part of a study being conducted in a phase I, phase II, phase III or phase IV clinical trial.

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

- One of the National Institutes of Health (NIH).
- A NIH cooperative group or center.
- The United States FDA in the form of an Investigational new drug application.
- The United States Department of Defense.
- The United States Department of Veterans Affairs.
- A qualified research entity that meets the criteria established by the NIH for grant eligibility.

A panel of qualified recognized experts in clinical research within academic health institutions in this state. The proposed treatment or study has been reviewed and approved by an institutional review board of an institution in this state.

The personnel providing the treatment or conducting the study:

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

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

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

Benefits do not, however, include the following:

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

Cochlear Implants

The Plan covers Medically Necessary Cochlear Implants and related services for Covered Persons with severe to profound sensorineural hearing loss. To be covered, all surgeries, services, and supplies must be provided by a Network Provider.

Covered Services Include:

- Cochlear Implants: The cost of Medically Necessary Cochlear Implants, including both the surgically implanted internal component and the external speech processor and controller.
- Related Services: Surgical implantation, fitting and dispensing services, and Medically Necessary treatments related to the Cochlear Implant, including Habilitation and Rehabilitation services.

Benefit Limitations:

- Implants: Coverage is limited to one (1) Cochlear Implant per ear.
- External Components: The replacement of an external speech processor and controller for a Cochlear Implant is strictly limited to one (1) replacement every three (3) years.
- Prior Authorization: All surgical procedures for cochlear implantation, device components, and related Rehabilitation services require Prior Authorization to verify Medical Necessity.
- Network Requirements: As an EPO, the surgery, device dispensing, and follow-up care must be performed by a Network Provider. Out-of-Network services are not covered unless specifically authorized in advance by the Plan due to network inadequacy.
- Cost Sharing: Covered surgeries, devices, and professional services are subject to applicable cost sharing as outlined in your Schedule of Benefits.

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. Prescription contraceptive Drugs are available in a three-month supply of the covered prescription contraceptive Drug at one time the 1st time the Covered Person obtains the Drug. A 12-month supply of the covered prescription contraceptive Drug at one time each subsequent time the Covered Person obtains the same Drug, regardless of whether the Covered Person was enrolled in the Plan the first time they obtained the Drug. A Covered Person may obtain only one 12-month supply of a covered prescription contraceptive Drug during each 12-month period. If You are utilizing an oral contraceptive that is not on the Formulary or that is on a tier higher than the preventive tier, You or Your Provider can seek an exception for the contraceptive. We will provide You with an override so that non-Formulary or non-preferred medication will process at no cost to you.

Diabetes Services

Diabetes Self-Management Training and Education Services

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

Diabetes self-management training and educational services includes coverage for medical nutrition therapy when prescribed by a Health Care Provider and when provided by a certified, registered, or licensed Health Care Provider. Benefits also include medical eye exams (dilated retinal exams) and preventive foot care, and diabetic specific foot orthotics, orthopedic shoes, 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, biohazard disposable containers, glucagon emergency kits and single measurement glucose monitors, including those for the legally blind, excluding continuous glucose monitors, are described under the Prescription Drug benefit. An insulin pump and continuous glucose monitors are subject to all the conditions of coverage stated under Durable Medical Equipment (DME).

Coverage for any other device, medication, equipment or supply for which coverage is required under Medicare guidelines pertaining to diabetes management is also included.

Dialysis

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

You may receive hemodialysis in an In-Network Dialysis Facility or peritoneal dialysis in Your home 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 and other diagnostic breast imaging to evaluate an abnormality detected by a Health Care Provider or the Covered Person;
- 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;
- Diagnostic follow-up care related to the screening tests for hearing impairment from birth through the date the Child is 24 months.
- 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 of time than it would cost to purchase equipment. If You purchase an item that exceeds the minimum specifications for Your needs, We will pay only the

amount that We would have paid for the item that meets the minimum specifications, and You will be responsible for paying any difference in cost.

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

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

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

Early Detection Tests for Cardiovascular Disease

Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:

- Computed tomography (CT) scanning measuring coronary artery calcifications; or
- Ultrasonography measuring carotid intima-media thickness and plaque.

Tests are available to each Covered Person who is a male older than 45 years of age and younger than 76 years of age, or a female older than 55 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Emergency Services

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

Continuation of care from an Out-of-Network Provider beyond that needed to evaluate or Stabilize Your condition in an emergency will be covered as an Out-of-Network service unless We authorize the continuation of care and it is Medically Necessary.

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

For Emergency Services, Prior Authorization is not required. If You are admitted to an Inpatient Hospital and Your condition has Stabilized, You or the Hospital must notify Us of the Inpatient admission so that We can concurrently review the Medical Necessity of the continued Inpatient stay. It is recommended that You or the Hospital notify Us within 24 hours of the point Your Physician has determined that Your condition is stable.

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

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

Surprise bills may occur in three distinct circumstances:

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

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

The NSA does not protect You from bills from the following services. However, additional balance billing protections may apply under applicable Texas law.

- Ground Ambulance transportation, except as otherwise protected from balance billing under applicable Texas law, including Emergency Ground Ambulance services.
- In-Network Providers and facilities that are contracted by Us.

- Out-of-Network Providers who do not practice at an In-Network Facility.
- Certain medical facilities, including Urgent Care Centers, birthing centers, Hospice facilities, addiction treatment centers, and nursing homes.

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

Family Planning Services

Covered Services and supply expenses for family planning include:

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

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 Investigational. Benefits for Habilitative Services do not apply to health care services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

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

Developmental Delay Therapy for Children Ages 2–6

Plan also covers Rehabilitative and Habilitative Services for a Child age 2 through 6 who has been diagnosed with a developmental delay or pervasive developmental disorder. Covered Services include physical therapy, occupational therapy, speech therapy and other Medically Necessary therapies that are part of a treatment plan to promote age-appropriate development or improve functional skills. These services are covered on the same basis as other Habilitative Services. Services must be provided by a licensed or certified Provider acting within the scope of their license and may not be solely educational in nature.

Hearing Aids

The Plan covers Medically Necessary Hearing Aids and related services for Covered Persons. To be covered, all services and supplies must be provided by a Network] Provider, unless a network exception is approved in advance by the Plan.

Covered Services Include:

- Hearing Aids: The cost of a Medically Necessary Hearing Aid (defined as a non-implantable device).
- Related Services: Fitting and dispensing services, ear molds, and necessary treatments related to the Hearing Aid, including Habilitation and Rehabilitation services.

Benefit Limitations:

- Coverage is strictly limited to one (1) Hearing Aid per ear every three (3) years.
- Prior Authorization: Rehabilitation Services associated with the use of a Hearing Aid may require Prior Authorization to verify Medical Necessity.
- Network Requirements: As an EPO, benefits are only payable when dispensed and serviced by a Network Provider who is a licensed audiologists, hearing aid fitter, or otolaryngologist. Out-of-Network services are not covered.

Cost-Sharing: Covered services are subject to applicable as outlined in your Schedule of Benefits.

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. Services must be prescribed by the attending Physician as part of a treatment plan, and the attending Physician must certify that Hospitalization or confinement in a Skilled Nursing Facility would be required if Home Health Care was not provided. Services must be Medically Necessary. 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. Services performed by Home Health Care organizations or agencies must be Medically Necessary and require Prior Authorization.
- Therapy Services.
- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).

Non-Covered Services include 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 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.

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 Care.

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.
- In accordance with state requirements, services additionally include:
    - Radiation therapy.
    - Inhalation therapy.

    - Administration of whole blood and blood plasma.
    - Short-term rehabilitation Therapy Services provided in the Acute hospital setting.
- Physician Services You receive during an Inpatient stay.

Infertility Services

We cover services for the diagnosis 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 a medical condition that results in infertility (e.g., endometriosis, blockage of fallopian tubes, varicocele, etc.).

Plan provides coverage for fertility preservation services for a Covered Person who will undergo a Medically Necessary cancer treatment (including chemotherapy, radiation, or surgery) that the American Society of Clinical Oncology (ASCO) or American Society for Reproductive Medicine (ASRM) has determined may directly or indirectly impair fertility.

Covered fertility preservation services include:

- Collection and preservation of sperm
- Collection and preservation of unfertilized oocytes (eggs)
- Collection and preservation of ovarian tissue

Important limitation: Coverage does not include storage of sperm, oocytes, or ovarian tissue

The following procedures are not covered: artificial insemination, IVF, GIFT, ZIFT, services for storage of sperm, oocytes, or ovarian tissue 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.

We also cover Chimeric Antigen Receptor (CAR) T-cell therapy when Medically Necessary and administered by a Network Provider. Provider must be qualified as a

certified health care facility in accordance with the procedure for CAR T-cell therapy approved by the FDA.

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 provide coverage for preventive mammography screening and Diagnostic imaging performed on dedicated equipment for Diagnostic purposes by a Covered Person's Physician and in accordance with state law, subject to all of the terms and conditions of this Plan, including:

- A mammogram.
- Digital breast tomosynthesis, magnetic resonance imaging, ultrasound or other modality and at such age and intervals as recommended by the national comprehensive cancer network. This includes patients at risk for breast cancer who have a family history with one or more first or second degree relatives with breast cancer, prior diagnosis of breast cancer, positive testing for hereditary gene mutations or heterogeneously or dense breast tissue based on the breast imaging reporting and data system of the American College of Radiology.

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.

Minimum Inpatient Stay: If due to treatment of breast cancer, any Covered Person of this Plan has either a mastectomy or a lymph node dissection, this Plan will provide coverage for Inpatient care for a minimum of:

- 48 hours following a mastectomy; and
- 24 hours following a lymph node dissection.

The minimum number of Inpatient hours is not required if the Covered Person receiving the treatment and the attending Physician determines that a shorter period of Inpatient care is appropriate.

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 Complications of Pregnancy, miscarriage, Therapeutic Abortion, and ordinary routine nursery care for a healthy newborn. Coverage also includes non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a stage of pregnancy in which a viable birth is not possible. If You are pregnant when Your benefits begin, please refer to the Continuity of Care section in Section III: HOW YOUR PLAN WORKS.

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

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

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

Notification and Coverage of Pregnancy Surrogacy

You should notify Us immediately if You as the Covered Person intend to enter into an agreement to be a surrogate mother or have agreed to be a surrogate mother. All pregnancy related services provided to a surrogate mother are not covered, including but not limited to, charges related to the baby’s birth, Hospitalization, or care because of surrogacy.

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 during a clinical trial that is deemed an Experimental or Investigational treatment if the services provided are otherwise considered Covered Services under the contract.
- Cytologic screenings for cervical cancer.
- Cochlear implants.
- Vision correction because of surgery or accident.
- Medically Necessary Telehealth services to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the Provider for Telehealth is at a distant site. Telehealth services are subject to the same clinical and Utilization Review criteria, Plan requirements, limitations, and Cost-Sharing as the same health care services when delivered to an insured in person. Medically Necessary virtual care encompasses Telehealth services. This is provided on the same basis and to the same extent (included Cost Shares) for the provision of in-person health care services.
- Medically Necessary services for complications arising from medical and surgical conditions.

Medical and Surgical Supplies

Coverage for non-durable medical supplies and equipment for management of disease and treatment of medical and surgical conditions. Covered Services and supplies may include, but are not limited to:

- Allergy serum extracts.
- Chem strips, Glucometer, Lancets.
- Clinitest.

- Needles/syringes.
- Medically Necessary ostomy bags and supplies, 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

Amino Acid-Based Elemental Formulas

Your Plan will cover an amino-acid-based elemental formula when Your treating Network Provider gives a written order stating that the formula is Medically Necessary. Coverage applies regardless of the method of delivery or administration. Benefits are available when the formula is used to diagnose or treat any of the following conditions:

- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- Severe food protein-induced enterocolitis syndromes;
- Eosinophilic disorders, as evidenced by the results of biopsy; and
- Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

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. Copayment or Cost Share Percentage amounts, quantitative treatment limitations and nonquantitative treatment limitations applicable for covered Mental Health Conditions and Substance Use will be applied in the same manner, and no more restrictively than those applied to medical and surgical health benefits. 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 and Texas laws 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 Physician services, Diagnostic Services, Therapy Services, surgery, rehabilitation, therapeutic radiology, Home Health Care, preventive, Mental Health Conditions, Emergency Services or other Provider Facility as determined by us. Any Cost Share Percentage will still apply to these health care services.

Physician-Administered Drugs

The Plan provides benefits for Physician-Administered Drugs in accordance with applicable Texas law for Covered Persons with a chronic, complex, rare, or life-threatening medical condition. For purposes of this section, the term Physician-Administered Drug includes a clinician-administered Drug as defined by applicable Texas law.

Except as otherwise permitted by applicable Texas law—including when a Drug is administered in a hospital, hospital facility-based practice setting, or hospital outpatient infusion center, or when the prescribing provider has not determined that standard network dispensing would cause a delay in care or patient harm— the Plan will not:

- Require a Physician-Administered Drug to be dispensed only by a designated Specialty or Network Pharmacy.
- Deny, limit, reduce, or otherwise restrict coverage of an otherwise covered Physician-Administered Drug based solely on the Covered Person's selection of a Pharmacy or because the Drug was not dispensed by a Network Pharmacy.
- Require a Network Provider to obtain, bill for, or be reimbursed for a Physician-Administered Drug under the Prescription Drug benefit instead of the medical benefit.
- Impose additional Cost-Sharing, including a Copayment, Cost Share Percentage, second Copayment, second Cost Share Percentage, fee, or other charge, based solely on the Covered Person's selection of a Pharmacy or because the Drug was not dispensed by a Network Pharmacy.

Nothing in this section prevents the Plan from applying Medical Necessity requirements, Prior Authorization, Utilization Review, site-of-care review, or other coverage requirements otherwise permitted under this Policy and applicable law. Such requirements will be administered in a manner consistent with applicable Texas law governing Physician-Administered Drugs.

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:

How billing works: Preventive services are covered at no cost to You when provided by a Network Provider and when the service is recommended for Your age and situation.

If You receive other non-preventive services during the same visit, Cost-Sharing may apply to those additional services.

- 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 preventive mammography screening and Diagnostic imaging performed on dedicated equipment for diagnostic purposes, including digital breast tomosynthesis, magnetic resonance imaging, ultrasound or other modality at such age and intervals as recommended by the national comprehensive cancer network and in accordance with state law. This includes patients at risk for breast cancer who have a family history with one or more first or second degree relative with breast cancer, prior diagnosis of breast cancer, positive testing for hereditary gene mutations or dense breast tissue based on the breast imaging reporting and data system of the American College of Radiology.
- 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 or the telephone number on Your ID Card. Prenatal and postnatal lactation support and counseling from In-Network obstetricians and Providers are also

included. To locate Network Providers that provide these services, please visit antidotehealth.com.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any 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 and Cost Share Percentage 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 Copayment and Cost Share Percentage for those services.

Covered Preventive Services for Adults include:

- Abdominal Aortic Aneurysm one-time screening for adults of specified ages who have ever smoked;
- Alcohol misuse screening and counseling;
- Aspirin used to prevent cardiovascular disease for adults of certain ages;
- Blood pressure screening for all adults;
- Cholesterol screening for adults of certain ages or at higher risk;
- Colorectal Cancer screening for adults age 45 and over, including a Medically Necessary follow-up screening after an initial abnormal screening test or procedure, as required by applicable law;
- Prostate Cancer exam for men over 50 or men over 40 with a family history of prostate cancer or prostate cancer risk factors.
- 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;
- Periodic health evaluation for each adult, which includes a health risk assessment at least once every three (3) years;
- Hepatitis C screening for adults at increased risk, and one time for adults age 18-79;
- 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 50-80 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;
- Preventive mammography screening and Diagnostic imaging performed on dedicated equipment for diagnostic purposes by a Covered Person's Physician, subject to all of the terms and conditions of this Policy, including:
    - A mammogram
    - Digital breast tomosynthesis, magnetic resonance imaging, ultrasound or other modality and at such age and intervals as recommended by the national comprehensive cancer network. This includes patients at risk for breast cancer who have a family history with one or more first or second degree relatives with breast cancer, prior diagnosis of breast cancer, positive testing for hereditary gene mutations or heterogeneously or dense breast tissue based on the breast imaging reporting and data system of the American College Of Radiology;
- Breast cancer chemoprevention counseling for Covered Persons at higher risk;
- Breastfeeding comprehensive support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing Covered Persons;
- Cervical cancer screening;
- 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;
- FDA-approved Human Papillomavirus (HPV) Test;
- 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;
- CA-125 blood test;
- Syphilis screening for all pregnant Covered Persons or other Covered Persons at increased risk;
- Annual preventive visit to support ongoing health needs; 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. Rehabilitation Services that Your Provider determines are Medically Necessary will not be denied, limited, or terminated if the service or therapy meets or exceeds Your treatment goals.

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

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

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

Other Therapy Services

The Plan will provide benefits for Therapy Services for:

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

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

We will also cover orthognathic (jawbone) surgery for a medical condition or 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 for a live donor when the donor is providing an organ to a Covered Person. Donor medical expenses will be covered under the recipient's benefits as long as transplant-related benefits remain available under this Plan. The donor's own insurance, if any, will be secondary.

Covered donor services include evaluation, testing, organ procurement procedures, and treatment of complications related to the donation. Benefits are provided whether the donor is covered under this Plan or not.

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 Cost Share Percentage or Copayment. 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. Certain Urgent Care services are available by contacting Antidote at 888-623-3195 or antidotehealth.com/member.

Urgent Care received at any Hospital emergency department is not covered unless authorized in advance by us. Covered Persons are encouraged to contact their Network Provider 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.

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, Cost Share Percentage), 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.

Any help You receive to pay for Your Prescription Drugs such as Copayment cards, coupons, discounts, vouchers, or financial assistance will be counted toward Your Copayment, Cost Share Percentage, and Out-of-Pocket maximum. This protects You from paying more than necessary.

We update the Antidote Formulary on an ongoing basis in accordance with federal and state law. Drugs may be added or removed, or additional requirements may be added in order to approve continued usage of a specific Drug. We will notify You of any Formulary changes that affect Your coverage. If a Drug is removed from the Formulary or coverage is reduced, We will continue to cover the Drug until Your renewal date. Any modification to Drug coverage, including removal of a Drug from

the Formulary or addition of new utilization management requirements, will occur only at the time of renewal and will be implemented uniformly across all Plans, with written notice provided at least 60 days in advance. To ensure Your safety and promote the appropriate use of pain medications, especially opioids, the Plan has a Patient Safety and Pain Management Program. This program is designed to help coordinate care for Covered Persons who may be at risk for medication overutilization.

Our clinical team, including pharmacists and nurses, reviews pharmacy claim information to identify members who may be receiving multiple prescriptions for controlled substances from several different doctors or filling them at multiple pharmacies. This review is sensitive to Your medical needs and does not solely consider the number of prescriptions filled. Its purpose is to identify situations where care may be uncoordinated and could pose a safety risk.

If We identify a potential safety or overutilization risk, a member of our Care Management team may reach out to You and Your treating provider(s) to create a Personalized Pain Management Plan. This voluntary plan is designed to improve the coordination and safety of Your care. As part of this plan, we may ask You to agree to:

- Receive all Your prescriptions for pain medication from a single, designated provider (such as a pain management Network Specialist).
- Fill all Your prescriptions for these medications at a single, designated pharmacy.

If a Personalized Pain Management Plan is established, Our claims system will be configured to cover these medications only when they are prescribed and dispensed by the Network Provider and Network Pharmacy You have designated. This care management approach helps ensure Your treatment is safe, effective, and well-coordinated.

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

If You have a question regarding whether a Drug is on the Formulary, please visit Our website at antidotehealth.com/pharma or call Us at the toll-free number on Your ID Card.

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 Policy. 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 Cost Share Percentage 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.

For purposes of this section, a "covered Formulary Insulin Drug" is defined strictly in accordance with Texas Insurance Code § 1358.103 as a covered Prescription Drug containing insulin used to treat diabetes (excluding intravenously administered insulin). This definition does not include non-insulin prescription Drugs, including but not limited to glucagon-like peptide-1 (GLP-1) receptor agonists, even if prescribed for diabetes management. To the maximum extent permitted by applicable law, combination Drugs containing both insulin and a non-insulin active ingredient are not subject to the Insulin Cost-sharing Cap and will be subject to the Cost-Sharing of their assigned Formulary tier.

Insulin Cost-Sharing Cap: The total amount You will be required to pay for a covered Formulary insulin Drug will not exceed $25 per prescription for up to a 30-day supply, or any lower limit required by any applicable state and/or federally mandated limits. Emergency refills of insulin and insulin-related equipment will be covered in the same manner as non-emergency refills.

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 Plan reserves the right to apply utilization management strategies, including but not limited to Prior Authorization, Step Therapy, and Quantity Limits, to any covered drug (including GLP-1 receptor agonists and Specialty Drugs) to determine coverage and Medical Necessity.

The different tiers are below:

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

Network Pharmacies agree that what You pay for your prescription will be the lowest of Your Copayment, the Plan's Allowed Amount for the Drug or the price You would pay if You bought the Drug without insurance or discounts. This means You will never pay more than the lowest price of these options.

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/pharma 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/find-a-doctor. 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/pharma.

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/pharma. 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.

Prescription Drug Synchronization

Texas law gives You the right to ask Us to synchronize Your prescription refills. This means You can align Your refill dates so that all Your medications can be refilled on the same day, instead of different days throughout the month.

For example, if you usually refill Drug A on the 1st of each month, but you start Drug B on the 15th, you can ask for a shorter or longer refill for Drug B. This helps You move Drug B's refill date to match Drug A's refill date. We will also adjust your Copayment, so You only pay for the amount You receive.

If you want to use this benefit, please call the telephone number of the back of Your ID Card to request Prescription Drug synchronization.

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 medication is being prescribed to treat a serious Mental Health Condition, We will not require You to try and fail more than one different medication before covering the Drug Your Provider recommends, unless it is a Generic Drug or pharmaceutical equivalent. We may only require this kind of step therapy once per year, and only if the alternative Drug is already on Our Formulary. The step therapy protocol does not apply to Prescription Drugs associated with the treatment of stage four advanced, metastatic cancer or associated conditions.

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 twenty-four (24) hours for urgent requests, and within seventy-two (72) hours for all other requests. If We do not deny the request within the applicable timeframe, the exemption request is considered granted. If the exemption is granted, You will be able to obtain the requested medication without needing to proceed through the step therapy protocol.

NOTE: If We deny Your Provider's request for an exemption, You and Your Provider may appeal the decision. We will respond to appeals within twenty-four (24) hours for expedited appeals, and within seventy-two (72) hours 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/education-resources.

Orally Administered Chemotherapy

Benefits for orally administered cancer treatment medications will not be less favorable than the benefits for cancer treatment medications that are administered intravenously or by injection.

Prescription Eye Drops

Eye drops to treat a chronic eye disease or condition, refills are dispensed on or before the last day of the prescribed dosage period, but not earlier than the following:

- 21st day after the date a prescription for a 30-day supply of eye drops is dispensed;
- 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed; or
- 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

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 Cost Share Percentage 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, the change will become effective at the time of Your renewal and Navitus will notify You at least 60 days in advance of the effective date of the change. If We approved or covered a Drug for Your condition, We will continue to cover the Drug at the same benefit level until Your coverage renewal date. This applies even if We remove the Drug from the Formulary before Your coverage renewal date.

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.
- Compound Drugs unless there is at least one ingredient that requires a prescription.

SECTION VI – EXCLUSIONS AND LIMITATIONS

No benefits will be provided or paid for:

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

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

- Administered or ordered by a Physician or other licensed Health Care Provider acting within the scope of their license; 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 gender affirming care.
- 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 learning disabilities.
- For diagnosis or treatment of nicotine addiction, except as expressly provided for under Preventive Care Services.
- For eye refractive surgery when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
- While confined primarily to receive rehabilitation, Custodial Care, educational care, or nursing services (unless expressly provided for in this contract).
- For vocational or recreational therapy, vocational rehabilitation, Outpatient speech therapy, or occupational therapy, except as expressly provided for in this contract.
- For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
- For eyeglasses, contact lenses, 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, or other routine maintenance supplies except as expressly provided in this contract. The Plan strictly excludes OTC hearing devices, BAHAs, and devices not prescribed and dispensed following a clinical hearing evaluation.
- Cochlear implant benefit does not cover the purchase of batteries, cords, alternative cosmetic faceplates, or routine external maintenance. Standard maintenance or upgrades requested solely for technological advancement (when the current processor is still functional) are not Covered Services.
- For Experimental or Investigational treatment(s) or unproven services. The fact that an Experimental or Investigational 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 Investigational treatment or unproven service for the treatment of that particular condition. These services may be related to medical, surgical, diagnostic, psychiatric, Substance Use or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan to be:
    - Not approved by the FDA to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
    - The subject of review or approval by an Institutional Review Board for the proposed use;
    - The subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of

whether the trial is subject to FDA oversight (except as set forth in the Cancer Clinical Trials provision of this Plan under Covered Services and Supplies; or
    - Not demonstrated, through existing peer reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
- For treatment received outside the United States, except for Emergency Services while traveling for up to a maximum of ninety (90) consecutive days.
- Transportation, lodging and travel related expenses.
- Transplant or post-transplant care if the transplant was performed in China, or another country known to have participated in forced organ harvesting.
- A transplant for which the organ to be transplanted was procured by sale or donation.
- 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. 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.

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

- For or related to treatment of hyperhidrosis (excessive sweating).
- For fetal reduction surgery.
- Except as specifically identified as a Covered Service expense under the contract, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- For court ordered testing or care unless Medically Necessary.
- For any injectable medication or biological product that is not expected to be self-administered by the Covered Person at the Covered Person's place of residence unless listed on the Formulary.
- 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
- For any medicinal and recreational use of cannabis or marijuana.

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 Provider to set health goals, and getting an annual checkup are just some of the ways You can start Your journey to better health.

A. Wellness and Rewards Program Overview and General Standards

As part of our commitment to Your health, Antidote offers a voluntary Wellness and Rewards Program ("Program") designed to encourage and support You in making healthy lifestyle choices. This Program is offered in accordance with Texas law:

- The Program has a reasonable probability of improving the health of, or preventing disease in, participating individuals. Activities and goals are based on evidence-based medical guidelines to promote wellness, utilizing proven and generally accepted methods for disease prevention and health promotion.
- The Program is not overly burdensome. Participation is voluntary, and You will never be required to participate as a condition of Your health coverage. The activities are designed to be reasonably achievable.
- The Program does not discriminate based on Your health status or medical history. Rewards are earned for participating in healthy activities, rather than for achieving a specific medical outcome. All members have an equal opportunity to participate and earn rewards, regardless of their current health.

B. Program Disclosure: Non-Insurance Benefit

Please be advised that the Wellness and Rewards Program is not an insurance benefit and is not part of Your Policy. The Program provides incentives, such as gift cards or other items of value, in exchange for completing designated health-related activities. These rewards are separate from and do not affect Your medical benefits, Premiums, or Cost-Sharing obligations under this Policy.

C. Program Availability and Termination

Your eligibility to participate in the Program is conditioned upon Your active enrollment in the Plan. As this is a non-insurance benefit, Antidote reserves the right to modify, suspend, or terminate the Wellness and Rewards Program, or any part thereof, at any time and for any reason. In the event the program is terminated, Antidote will provide reasonable advance notice to members. Your participation and eligibility for rewards will end automatically on the date that Your health coverage with Antidote terminates.

For more information on currently available wellness activities and rewards, please log into Your online member account or call Member Services at the number on Your ID Card.

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 eligible for 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 lawfully present individual 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 Texas 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 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 60th 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 60th day after the date of birth. The required Premium will be calculated from the Child's date of birth. If notice of the newborn is given to Us by the Health Insurance Marketplace within the 60 days from birth, an additional Premium for coverage of the newborn Child will be

charged for not less than 60 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 61st 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 Texas.
- Your domestic partner under the terms and conditions of this Policy 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;
    - Stepchildren;
    - Children awarded coverage pursuant to an order of the court;
    - Foster Children who are placed by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
    - An adopted Child, including a Child who is placed with You for adoption, is automatically covered for sixty (60) 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;
    - Your own, or Your Spouse's newborn Children are automatically covered for the first sixty (60) 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; and
    - Grandchildren if the grandchild is: unmarried, younger than 25 years of age and a Dependent of the enrollee for federal income tax purposes at the time application for coverage of the grandchild is made.

- 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 sixty (60) days of life upon notification to Us. To continue coverage past that time, You must enroll the Child as an insured family member by applying for their enrollment as a Dependent within sixty (60) days of the date of birth and pay any additional Premium. If You serve as a surrogate for another individual or couple, any Child born as a result of that surrogacy arrangement will not be considered a Dependent of You and will not be eligible for coverage under this Plan.

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

Coverage for a Disabled Dependent Child

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

- The Dependent Child is not able to support him/herself because of mental, developmental, or physical disability; and
- The Dependent Child depends mainly on the 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. 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 – RENEWAL, CONTINUATION, NONRENEWAL and TERMINATION

Guaranteed Renewability

This Policy is guaranteed renewable at Your option, subject to applicable federal and Texas law. We will renew this Policy each year unless We have a lawful reason to nonrenew, discontinue, or terminate this Policy described in this Section and permitted by applicable federal and state laws. We may change Premium rates or make changes to this Policy at renewal as permitted by applicable law.

Policy Term

The initial term of this Policy commences on the Policy Effective Date and continues through the Benefit Period. Coverage will begin at 12:01 a.m. on the Effective Date and end at 11:59 p.m. on the applicable termination date in the time zone where You live. This Policy 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 Policy and/or all similar policies for the reasons explained in this Policy.

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

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

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

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

In addition to the reasons listed in the General Termination Provisions section of this Policy, Your coverage will end for any of the following reasons:

- **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**
  Payments of Premiums by Third Parties: This Policy requires that You, the Subscriber, pay the Premiums for Your coverage. Antidote does not accept Premium payments made on Your behalf by third parties, unless such payments are specifically required by federal or state law or have been expressly approved by Antidote.

  Prohibited third-party payments include, but are not limited to, payments made by healthcare providers, commercial entities, or other unapproved organizations. Accepting payments from such prohibited sources is a violation of a material provision of this Policy.

  This limitation does not apply to Premium payments made by:

    - A family member;
    - Federal or state government programs or grantees, including the Ryan White HIV/AIDS Program; or

- An Indian tribe, tribal organization, or urban Indian organization.

If Antidote discovers that prohibited third-party payments have been made and accepted on Your behalf, we may reject such payments. Consistent with Texas law, we reserve the right to terminate Your coverage for violating this material provision of Your Policy, following the applicable thirty (30) day written notice period.

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 Policy 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 Policy 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 Cost Share Percentage and Copayment amounts.

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

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. The Copayment amount shall not exceed 50% of the total cost of the services provided. Copayments paid by You or on Your behalf in a Calendar Year shall not exceed 200% of the total annual Premium.

Cost Share Percentage Amounts

Some of the care and treatment You receive under Our Plan will require that a Cost Share Percentage be paid at the time You receive the services. Refer to Your Schedule of Benefits for Your specific Cost Share Percentage information.

Except where stated otherwise, 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 Copayment amounts, and Cost Share Percentage amounts, are applied to the maximum Out-of-Pocket.

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

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

Family Maximum Out-of-Pocket

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

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

When the family maximum Out-of-Pocket is reached for a family in a Year, Covered Service expenses for that family, except as described below, are payable at 100% for the remainder of the Plan Year by Us. The family Out-of-Pocket maximum amount can be met with the combination of any amounts paid towards one or more of Your individual Copayments and Cost Share Percentage.

Limitations and Exclusions. Refer to Your Schedule of Benefits for Cost Share 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 and Cost Share Percentage 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 monthly 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 sixty (60) 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. Each notice of a Premium change will include:

- a table showing the current Premium amount, the new Premium amount, and the percentage change;
- a statement that the notice is based on coverage in effect on the date of the notice;
- contact information for the Texas Department of Insurance, including instructions on how to file a complaint, as well as contact information for the Texas Consumer Health Assistance Program and website links to federal and state rate-increase justification resources; and
- a statement that You are not required to respond, renew, or take other action regarding the Policy until at least the 45th day after the date the notice is provided.

Notice of Premium increase at renewal or nonrenewable based on an attained age-

Annually, We will change the rate table used for this contract form. Each Premium will be based on the rate table in effect on that Premium's due date. The Plan, and age of Covered Person's, type and level of benefits and place of residence on the Premium due date are some of the factors used in determining Your Premium rates. We have the right to change Premiums, however, all Premium rates charged will be guaranteed for a calendar year.

Premium changes are subject to review and approval by the Texas 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 Policy 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/plandocs. Except for Emergency Services, services provided by an Out-of-Network Provider are considered non-Covered Services.

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

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

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

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

- At least five (5) days prior to an elective or scheduled admission as an Inpatient in a Hospital, extended care or rehabilitation Facility, or Hospice Facility or as soon as reasonably possible.
- At least thirty (30) days prior to the initial evaluation for organ transplant services or as soon as reasonably possible.
- At least thirty (30) days prior to receiving clinical trial services or as soon as reasonably possible.
- 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. See Section XIII – APPEALS AND COMPLAINT PROCEDURES.

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

Notice of Claim

A written notice of claim must be submitted to Us within twenty (20) days after expense was incurred, or as soon as reasonably possible. A notice given by or on behalf of the Covered Person to Us at Our address below or to an authorized representative, with sufficient information to identify the Covered Person, shall constitute a notice of claim. For Covered Services rendered by an In-Network Provider, the Provider's submission of a claim to Us satisfies this notice requirement.

Proof of Loss

Written proof of loss must be provided to Us within ninety (90) days after expense was incurred. We will not deny or reduce any claim if it is not reasonably possible to give proof within the required time.

Physical Examinations and Autopsy

At Our expense, We have the right to have a Covered Person, whose illness or injury is the basis of a claim, examined by a Health Care Provider of Our choice as often as is reasonably necessary while a claim is pending. In the event of death, We may require an autopsy, at Our expense, unless prohibited by law.

Legal Actions

An action at law or in equity may not be brought to recover under this Plan before the sixty-first (61st) day after the date written proof of loss has been provided in accordance with the requirements of this Plan. An action at law or in equity may not be brought after the expiration of three (3) years after the time written proof of loss is required to be provided.

Claim Submission

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

We will process all claims in accordance with Texas law. We will acknowledge receipt of a claim not later than the 15th day after we receive it. If additional information is needed, We will notify You or Your Provider within 15 days of receiving the claim.

A clean claim will be paid, denied or We will request additional information not later than the 15th day after We receive it. If We request additional information, We will pay or deny the claim not later than the 15th day after We receive all requested information.

If a claim is submitted without all information required to process it, We will notify You or Your Provider within 15 days and identify the additional information needed to complete the claim. Once the requested information is received, We will process the claim within the above timelines.

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 Direct

Member Reimbursement (DMR) form that can be found at [antidotehealth.com] or 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 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/forms. Send all the documentation to Us at the following address:

Antidote
Attn: Member Services, Antidote Health Plan
[1460 Broadway St
New York, NY 10036]

Reimbursement

Please be aware that submitting a request for reimbursement does not guarantee payment. Your request will be evaluated as a claim and is subject to all terms, conditions, and provisions of your specific health benefit plan. This means the service must be a Covered Service and must have been Medically Necessary. The reimbursement will be processed in accordance with all Plan policies, procedures, benefit limitations, Exclusions, Prior Authorization requirements, and Cost-Sharing obligations (including your Copayment and Coinsurance). If the service is not a Covered Service under your Plan, your request for reimbursement will be denied.

In the event You are required to make payment other than a required Copayment or Cost Share Percentage amount at the time Covered Services are rendered, We will ask that Your Provider reimburse You, or We will reimburse You.

Explanation of Benefits

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

SECTION XIII – APPEALS AND COMPLAINT PROCEDURES

Call Member Services

Please contact Our Member Services team at the toll-free number on Your ID Card if You have questions about Your benefits or any concerns.

You can file a complaint or an appeal at any time and doing so will not affect Your coverage. We will not cancel Your coverage, refuse to renew Your coverage, treat You differently or take any action against You. Your Provider is also protected. We will not take any negative action against a Provider who files a complaint or appeal on Your behalf.

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 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]. Oral appeals may be initiated by calling the telephone number on Your ID Card.

For internal appeals not requiring an expedited timeline, the appeal will be considered within thirty (30) calendar days after We receive it. We will provide Adverse Determination notices in writing that include the principal reason for the denial, the clinical basis for the decision, a description of or the source of the screening criteria that were used, and specialty of the physician or other Health Care Provider who issued the

determination. The notice will also describe Your appeal rights and Your right to request an Independent Review Organization review, if applicable.

Expedited Internal Appeal - Standard

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 or in the opinion of a physician with knowledge of Your condition, would subject You to severe paid than cannot be adequately managed without the requested care. 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 decide about the request no later than one (1) business day after receiving all information needed to make a decision. We will notify You and Your Authorized Representative of the result. In accordance with state law, We will include all required information related to Your right to request immediate IRO review when applicable.

Expedited Internal Appeal – Concurrent Review

You can file an expedited appeal when the Plan denies coverage for on-going care while You are currently in a hospital or other Inpatient facility. This is an appeal of a "concurrent review" decision to end an Inpatient stay. This type of appeal must be documented with clinical information.

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 decide about the request as required by applicable Texas law, taking into account the medical urgency of the Covered Person's condition. We will notify You and Your Authorized Representative of the result. In accordance with state law, We will include all required information related to Your right to request immediate IRO review when applicable.

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 administered through the Texas Department of Insurance (TDI) may be requested. You, or Your Authorized Representative, can request an external review by an Independent Review Organization (IRO) 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. We will send instructions and the approved TDI IRO request form with the denial notice. For non-urgent cases, complete, sign, and return the form to Us to begin the IRO process. We will forward it to the Texas Department of Insurance within one working day as required.

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/Investigational, 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 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 no later than the earlier of the 15th day after the IRO receives all information needed to decide, or the 20th day after the IRO receives the request for review. For life-threatening cases and certain ongoing Prescription Drugs or intravenous infusion cases, the IRO will provide its decision by telephone and follow with written or electronic notice no later than the fifth day after receiving the request or the necessary information, whichever is earlier.

For a denial of ongoing Inpatient care, You have the right to an immediate IRO review that happens at the same time as the Plan's forty-eight hour internal appeal.

You, Your Provider, or Your Authorized Representative may call Us to request this urgent review and give Us the required information over the phone.

You may file the request for an external review by contacting the Plan:

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

<u>Urgent Request for an External Appeal</u>

For a denial of pre-service care for a life-threatening condition, You have the right to request an immediate review by an Independent Review Organization (IRO). In these circumstances, You do not have to go through Our normal internal appeal steps first. You, Your Provider, or Your Authorized Representative may call Us to request this urgent review and give Us the required information over the phone.

For denials involving the interruption of an on-going course of treatment with a Prescription Drugs or intravenous infusions for which You are receiving benefits under a current course of treatment, the IRO will provide a determination by phone and follow

up with written or electronic notice no later than the fifth day after receiving either the necessary information or the 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 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 to the Independent Review Organization 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 Policy. You or Your Authorized Representative may request an external review for Experimental or Investigational Services only if Your treating Physician certifies that one of the following situations applies:

- Standard treatments have failed or are unlikely to help a Covered Person with a life-threatening or serious, degenerative, or disabling condition; or
- There is objective, scientifically valid evidence (e.g., peer-reviewed literature, clinical trials) indicating that the requested Experimental or Investigational Service treatment is more likely than not to be beneficial to the patient; and
- Standard health care services are not medically appropriate for the Covered Person; or
- There is no available standard health care service covered under this Policy that is more beneficial than the requested health care service.

SECTION XIV – GENERAL PROVISIONS

Assignment: You have the right to ask Us to send payment directly to the Physician or other licensed Health Care Provider who treated You. This is called an assignment of benefits, and We will honor when it is made in writing. You cannot transfer Your benefits under this Plan to any person, corporation, or other organization who is not a Health Care Provider except as permitted by law and We may verify the services You received were covered under Your Plan.

Change of Beneficiary: Unless the Covered Person makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to the Covered Person, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this Plan, for any change of beneficiary or beneficiaries, or for any other change to this Plan.

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

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 Texas on this contract's Effective Date or on any Premium due date is changed to conform to the minimum requirements of 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 Policy, along with the application, amendments, riders, endorsements, Schedule of Benefits and any other attachments constitute the entire contract between You and Us. The consideration for this Policy consists of the timely payment of all required Premiums. If an application is made a part of this Policy, the application also constitutes part of the consideration for this Policy. No change to this form is valid unless approved by Us and attached to the Policy. No agent has authority to:

- 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 knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison..

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: All statements made by a Covered Person in a signed application for coverage are representations and not warranties. No statement made for the purpose of obtaining coverage will be used to void this Policy or deny a claim unless it is contained in a written application or other written statement signed by the Covered Person making the statement, a copy of which is furnished to the Covered Person.

Except for fraud, after this Policy has been in force for two (2) years during the Covered Person's lifetime, We will not contest the validity of this Policy. After the second anniversary of the date this Policy has been in force, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for this Policy may not be used to void the Policy or deny a claim for loss incurred or disability commencing after that anniversary.

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 Policy is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Policy will remain in full force and effect.

Statement of Non-Discrimination

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

Antidote:

- Provides free aids and services to people with disabilities to communicate effectively with Us, such as:
    - Qualified sign language interpreters; and

    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters; and
    - Information written in other languages.

If You need these services, contact Antidote at the toll-free number on Your ID Card.

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

Antidote
Attn: Member Services, Antidote Health Plan
[1460 Broadway St
New York, NY 10036]

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

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

SECTION XV – TEXAS REQUIRED NOTICES

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise You of certain coverage and/or benefits provided by Your contract with Antidote. Required notices for mastectomy or lymph node dissection -

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this Plan has either a mastectomy or a lymph node dissection, this Plan will provide coverage for Inpatient care for a minimum of:

- 48 hours following a mastectomy; and
- 24 hours following a lymph node dissection.

The minimum number of Inpatient hours is not required if the Covered Person receiving the treatment and the attending Physician determine that a shorter period of Inpatient care is appropriate.

Prohibitions: We may not (a) deny any Covered Person eligibility or continued eligibility or fail to renew this Plan solely to avoid providing the minimum Inpatient hours; (b) provide money payments or rebates to encourage any Covered Person to accept less than the minimum Inpatient hours; (c) reduce or limit the amount paid to the attending Physician, or otherwise penalize the Physician, because the Physician required a Covered Person to receive the minimum Inpatient hours; or (d) provide financial or other incentives to the attending Physician to encourage the Physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Enrollment

Coverage and/or benefits are provided to each Covered Person for reconstructive surgery after mastectomy, including:

- all stages of the reconstruction of the breast on which mastectomy has been performed;
- surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
- prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the Covered Person and the attending Physician.

Prohibitions: We may not (a) offer the Covered Person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any Covered Person's eligibility or continued eligibility to enroll in the Plan or fail to renew this Plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the Physician or Provider, nor otherwise

penalize, or provide a financial incentive to induce the Physician or Provider to provide care to a Covered Person in a manner inconsistent with the coverage and/or benefits shown above.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Annual

Your contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

Inpatient Stay Following Birth of a Child

For each person covered for maternity/childbirth benefits, We will provide Inpatient care for the mother and her newborn Child in a health care Facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by Cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to: (a) give birth in a Hospital or other health care Facility or (b) remain in a Hospital or other health care Facility for the minimum number of hours following birth of the Child.

If a covered mother or her newborn Child is discharged before the 48 or 96 hours has expired, We will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a Physician, registered nurse or other appropriately licensed Health Care Provider, and the mother will have the option of receiving the care at her home, the Health Care Provider's office or a health care Facility.

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.

Prohibitions: We may not (a) modify the terms of this coverage based on any Covered Person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a Physician's recommendation for a specified period of Inpatient care made in consultation with the mother if the period recommended by the Physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the Usual and Customary

Rate; or (e) penalize a Physician for recommending Inpatient care for the mother and/or the newborn Child.

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized Diagnostic examination for the detection of prostate cancer. Benefits include:

- A physical examination for the detection of prostate cancer; and
- A prostate-specific antigen test for each covered male who is:
    - At least 50 years of age; or
    - At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factors.

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 45 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer.
Benefits include the Covered Person's choice of:

- a fecal occult blood test performed annually, and a flexible sigmoidoscopy performed every five years; or
- a colonoscopy performed every 10 years.

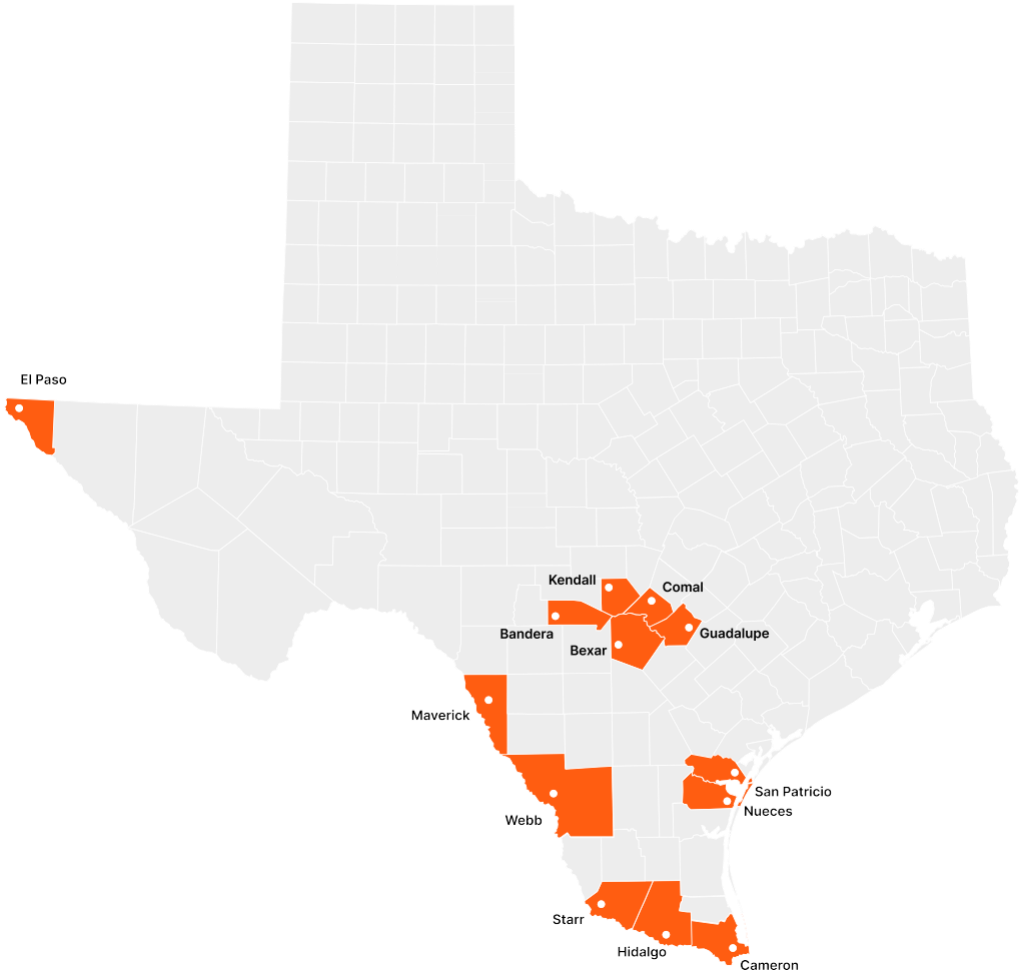
Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Coverage is provided for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual, medically recognized Diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.

If You have any questions concerning the above, please call Antidote at member services 888-623-3195, or write Us at:

Antidote
Attn: Member Services, Antidote Health Plan
[1460 Broadway St
New York, NY 10036]

Texas
PY 2027



Texas Partners at Health System Level

Health System	Counties
HCA Healthcare	El Paso, Nueces
Tenet	Bexar, Guadalupe, Cameron, Hidalgo, Comal, El Paso
Universal Health Services	Nueces, El Paso, Hidalgo, Bexar, Webb
Community Health Systems	Webb, Bexar

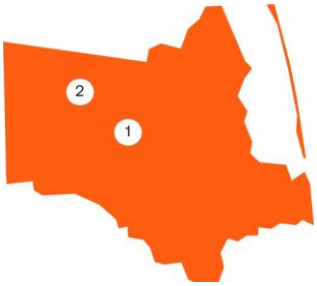
Antidote Health Mapping of Markets to Counties & Rating Areas

Primary City	Counties	Rating Area
Brownsville	Cameron	5
Corpus Christi	Nueces, San Patricio	7
El Paso	El Paso	9
Laredo	Webb	12
McAllen	Hidalgo, Starr	15
San Antonio	Bandera, Bexar, Comal, Guadalupe, Kendall, Maverick	18

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ANTIDOTE

Facilities by County



Brownsville:
Cameron

Label	Zip	Facility Name	County
	78520	Valley Baptist Medical Center - Brownsville	Cameron
2	78550	Valley Baptist Medical Center - Harlingen Valley Baptist Surgery Center, LLC d/b/a Platinum Surgery Center	Cameron

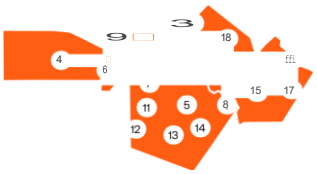


El Paso:
El Paso

Label	Zip	Facility Name	County
	79902	Behavioral Healthcare Center of El Paso Las Palmas Medical Center Providence Children's Hospital The Hospitals of Providence Memorial Campus The Hospitals of Providence Sierra Campus El Paso Center for Gastrointestinal Endoscopy, L.L.C. El Paso Day Surgery, L.L.C. Tenet Hospitals Limited d/b/a The Hospitals of Providence Memorial Campus Tenet Hospitals Limited d/b/a The Hospitals of Providence Sierra Campus	El Paso
2	79911	Tenet Hospitals Limited d/b/a The Hospitals of Providence Transmountain Campus	El Paso
3	79912	Surgery Affiliate of El Paso, L.L.C., d/b/a Paso Del Norte Surgery Center	El Paso
4	79925	Del Sol Medical Center	El Paso
5	79928	HCN EP Horizon City, L.L.C., d/b/a The Hospitals of Providence Horizon City Campus	El Paso
6	79934	HCN EP Horizon City, L.L.C., d/b/a The Hospitals of Providence Northeast Campus	El Paso
7	79936	HCN EP Horizon City, L.L.C., d/b/a The Hospitals of Providence Emergency Room Montwood	El Paso
8	79938	The Hospitals of Providence East Campus CRH of El Paso, LLC d/b/a The Hospitals of Providence Rehabilitation Hospital East Tenet Hospitals Limited d/b/a The Hospitals of Providence East Campus	El Paso

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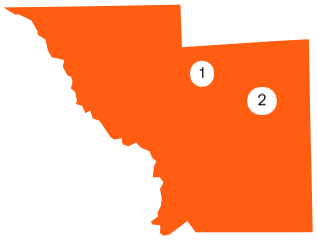


San Antonio:
Bandera, Bexar, Comal, Guadalupe, Kendall, Maverick

Label	Zip	Facility Name	County
	78251-3901	VHS San Antonio Partners, LLC d/b/a Westover Hills Baptist Hospital VHS San Antonio Partners, LLC d/b/a Cardiac Rehab Westover Hills	Bexar
2	78070	Legent Outpatient Surgery Singing Hills, LLC d/b/a Singing Hills Surgery Center	Bexar
3	78130	Resolute Hospital Company LLC d/b/a Resolute Health Hospital	Comal
4	78154	Emerus BHS SA Thousand Oaks, LLC d/b/a Baptist Neighborhood Hospital Schertz Schertz Surgery Center, LLC d/b/a Cibolo Creek Surgery Center	Guadalupe
5	78155	Guadalupe Regional Medical Center - Main Hospital	Guadalupe
6	78205	VHS San Antonio Partners, LLC d/b/a Baptist Medical Center VHS San Antonio Partners d/b/a Healthlink Cardiac Rehab VHS San Antonio Partners d/b/a Healthlink Downtown	Bexar
7	78215	GAB Endoscopy Center, LLC	Bexar
8	78216	VHS San Antonio Partners d/b/a Healthlink Bitters Road	Bexar
9	78217	VHS San Antonio Partners, LLC d/b/a Northeast Baptist Hospital VHS San Antonio Partners d/b/a Healthlink Cardiac Rehab VHS San Antonio Partners d/b/a Healthlink Northeast	Bexar
10	78220	EMERUS BHS SA Thousand Oaks, LLC d/b/a Baptist Neighborhood Hospital Rigsby	Bexar
11	78223	VHS San Antonio Partners d/b/a Healthlink Mission Trail	Bexar
12	78224	Southwest General Hospital Emerus BHS SA Thousand Oaks, LLC d/b/a Baptist Neighborhood Hospital Zarzamora VHS San Antonio Partners d/b/a Healthlink Southwest	Bexar
13	78229	St. Luke's Baptist Hospital First Choice Ambulatory Surgery Center, LLC d/b/a San Antonio Med Center Surgery Center GCSA Ambulatory Surgery Center, L.L.C. San Antonio Endoscopy, L.P. VHS San Antonio Partners, LLC d/b/a St Luke's Baptist Hospital VHS San Antonio Partners d/b/a Healthlink Medical Center Emerus BHS SA Thousand Oaks, LLC d/b/a Baptist Neighborhood Hospital Westover Hills VHS San Antonio Partners d/b/a Healthlink Camp Bullis VHS San Antonio Partners d/b/a Healthlink Ingram VHS San Antonio Partners d/b/a Healthlink Westover Hills VHS San Antonio Partners, LLC d/b/a Healthlink Wiseman	Bexar
14	78232	Emerus BHS SA Thousand Oaks, LLC d/b/a Baptist Neighborhood Hospital Thousand Oaks	Bexar
15	78233	GCSA Ambulatory Surgery Center, L.L.C.	Bexar
16	78235	Mission Trail Baptist Hospital VHS San Antonio Partners, LLC d/b/a Mission Trail Baptist Hospital	Bexar
17	78237	Emerus BHS SA Thousand Oaks, LLC d/b/a Baptist Neighborhood Hospital Kelly	Bexar
18	78240	Foundation Bariatric Hospital of San Antonio, LLC d/b/a Foundation Surgical Hospital San Antonio	Bexar
19	78244	Emerus BHS SA Thousand Oaks, LLC d/b/a/Baptist Neighborhood Hospital Converse	Bexar
20	78249	Emerus BHS SA Thousand Oaks, LLC d/b/a Baptist Neighborhood Hospital Hausman Emerus BHS SA Thousand Oaks, LLC d/b/a Baptist Neighborhood Hospital Shavano Park San Antonio Specialty Hospital, LLC d/b/a South Texas Specialty Hospital VHS San Antonio Partners d/b/a Healthlink Hausman	Bexar

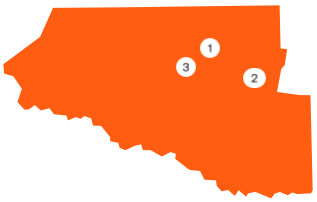
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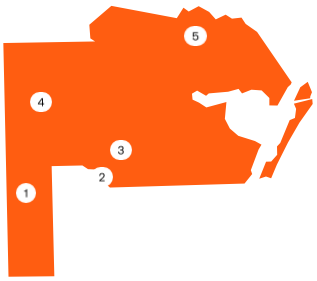
Laredo:
Webb

Label	Zip	Facility Name	County
1	78045	Doctors Hospital of Laredo	Webb
2	78041	Laredo Medical Center	Webb



McAllen:
Hidalgo, Starr

Label	Zip	Facility Name	County
1	78503	South Texas Health System McAllen South Texas Health System McAllen (Tenet)	Hidalgo
2	78539	Doctors Hospital at Renaissance – Main Campus South Texas Health System Edinburg	Hidalgo
3	78596	VHS Harlingen Hospital Company, L.L.C. d/b/a Valley Baptist Micro-Hospital Weslaco South Texas Health System Weslaco	Hidalgo



Corpus Christi:
Nueces, San Patricio

Label	Zip	Facility Name	County
1	78411	Corpus Christi Medical Center – Doctors Regional	Nueces
2	78412	Corpus Christi Medical Center – Bay Area	Nueces
3	78413	Corpus Christi Medical Center – The Heart Hospital	Nueces
4	78414	Texas Precision Surgery Center, LLC	Nueces
5	78416	Behavioral Healthcare Center of Corpus Christi	Nueces

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