ANTIDOTE

Antidote Health Plan of Georgia, Inc.

Individual Medical HMO Outline of Coverage

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

Effective Date: January 1, 2027

NOTICE

This is an individual Health Maintenance Organization (HMO) Plan issued by Antidote.

PLEASE CAREFULLY READ AND REVIEW THE ENTIRE EVIDENCE OF COVERAGE (EOC).

This Outline of Coverage (OOC) is a summary of Your health Plan benefits. It is not an insurance contract. The EOC, along with the Schedule of Benefits, amendments and riders contains the full terms of coverage and describes your rights and obligations under the Plan.

If there is any difference between this OOC and the EOC, the EOC will control.

To receive benefits under the Plan, You need to use Network Providers, except in certain situations such as Emergency care, when otherwise allowed under the Plan or required by law.

The Plan requires selection of a Primary Care Physician (PCP), Referrals for most specialty care and Prior Authorization for certain services.

ANTIDOTE HEALTH PLAN OF GEORGIA CONTACT INFORMATION:

Resource	Contact Information	Hours
Member Services Helpline	888-623-3195	Monday – Friday 7:00 AM to 1:00 AM Saturday and Sunday 8:00 AM to 1:00 AM
Urgent Care Helpline To assist You in locating an Urgent Care Network Provider, You may call Our Urgent Care Helpline for questions regarding Referrals to Network Providers that offer Urgent Care services and assistance with network exceptions. Urgent Care services received from a Network Provider do not require Prior Authorization. You may seek services from any Network Provider that offers such services without Prior Authorization. If You have any questions regarding Urgent Care, please call Our Urgent Care Helpline.	888-623-3195	Monday – Friday 7:00 AM to 1:00 AM Saturday and Sunday 8:00 AM to 1:00 AM
Website	antidotehealth.com	24 hours a day 7 days a week
Mailing Address	[PO Box 39638 Solon, OH 44139]	24 hours a day 7 days a week
Georgia Relay	Dial 7-1-1 or call one of the toll free numbers below: TTY: 800-255-0056 Voice: 800-255-0135 Speech-to-Speech: 888-202-4082 Spanish-to-Spanish: 888-202-3972	24 hours a day 7 days a week

Throughout this document, You will find statements that encourage You to contact Us for further information. Whenever You have a question or concern regarding Your benefits, please call

Member Services. It will be Our pleasure to assist You. In some areas, We have partnered with industry leading Specialists and may refer You to them for further assistance.

SECTION V – COVERED HEALTH CARE SERVICES

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

Accidental Dental

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

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

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

Ambulance Services

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

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

Non-emergency Ambulance transportation requires Prior Authorization.

Autism Spectrum Disorder

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

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

Psychologist, Psychiatrist, or Physician to provide consultation assessment, development, and oversight of treatment plans.

Behavioral Health Care Services

We cover services for mental health and substance use disorders. In accordance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA), benefits for these services, including financial requirements (like copayments) and treatment limitations (like visit limits or prior authorization requirements), are no more restrictive than the requirements for medical and surgical 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 Disorders and Substance Abuse services provided in a Hospital or other health care treatment Facility. These services include Inpatient psychiatric Hospitalization, Inpatient detoxification treatment, observation, and emergency evaluation and Stabilization.

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

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

- Individual or group psychotherapy with Physicians, Psychologists, or other mental health professionals authorized or licensed by the state in which they practice (e.g., licensed clinical Social Workers, Clinical Nurse Specialists, certified alcohol and drug counselors);
- Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy, if required, must be a component of the Physician’s treatment plan for the individual;
- Services of other staff (Social Workers, psychiatric nurses, and others) trained to work with psychiatric patients;
- Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes;
- Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient’s diagnosed condition and for progress toward treatment goals;
- Family counseling services for which the primary purpose is the treatment of the patient’s condition;
- Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual’s care and treatment of his/her diagnosed psychiatric condition;
- Medically Necessary Diagnostic services related to mental health treatment.

Intensive Outpatient Services. The Plan provides benefits for Intensive Outpatient Treatment

services offered by practice groups or Facilities that provide Behavioral Health Care Services. Intensive Outpatient Services programs are defined as those that provide a minimum of nine hours of structured therapeutic services per week]. The services may address Substance Abuse conditions, mental or behavioral health issues, or both, which are dual diagnosis programs. These programs are usually used as a step down from Acute Inpatient care, residential care, or a Partial Hospitalization program. They may also be viewed as a step up from regular Outpatient Services.

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

Coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations, including Deductibles, Copayment, and Coinsurance provisions that are less favorable than the limitations that apply to a physical sickness as covered under this EOC.

Chiropractic and Osteopathic Services

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

Clinical Trials

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

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

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

The treatment is being provided as part of a study being conducted in a phase I, phase II, phase

III or phase IV clinical trial.

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

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

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

The personnel providing the treatment or conducting the study:

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

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

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

Benefits do not, however, include the following:

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

Contraception

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

contraception is available to Covered Persons without a prescription and at no Cost Share to the Covered Person.

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

Diabetes Services

Diabetes Self-Management Training and Education Services

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

Diabetes self-management training and educational services includes coverage for medical nutrition therapy when prescribed by a Health Care Provider and when provided by a certified, registered, or licensed Health Care Provider. Benefits also include medical eye exams (dilated retinal exams) and preventive foot care, and diabetic specific foot orthotics, orthopedic shoes, inserts, modifications and footwear when Medically Necessary for the treatment of complications related to diabetes. Diabetic self-management supplies benefits for blood glucose control and testing including insulin syringes with needles, blood glucose and urine test strips, lancets and lancet devices, ketone test strips and glucose tablets, and single measurement glucose monitors, including those for the legally blind, excluding continuous glucose monitors, are described under the Prescription Drug benefit. An insulin pump and continuous glucose monitors are subject to all the conditions of coverage stated under Durable Medical Equipment (DME). 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 In-Network Provider when You qualify for home dialysis. Covered expenses include:

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

After You receive appropriate training at a Dialysis Facility We designate, We also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis.

Coverage is limited to the standard item of equipment or supplies that adequately meets Your medical needs. We will determine if equipment is made available on a rental or purchase basis. At Our option, We may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a Provider We authorize before the purchase.

Diagnostic Services

The Plan provides benefits for non-invasive Diagnostic Services, including but not limited to the following:

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

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

Durable Medical Equipment (DME)

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

- Canes.
- Cochlear implants and batteries for cochlear implants.
- Commode chairs.
- Continuous glucose monitors.
- Continuous passive motion devices.
- Continuous Positive Airway Pressure (CPAP) devices.
- Crutches.

- Hospital beds.
- Infusion pumps.
- Nebulizers.
- Oxygen equipment.
- Patient lifts.
- Pressure-reducing support surfaces.
- Suction pumps.
- Traction equipment.
- Trusses.
- Walkers.
- Manual Wheelchairs.

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

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

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

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

Emergency Services

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

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

For Emergency Services, Prior Authorization is not required. If You are admitted to an Inpatient Hospital and Your condition has Stabilized, You or the Hospital 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 federal 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.

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

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

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

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

Family Planning Services

Covered Services and supply expenses for family planning include:

- Medical history review.
- Physical examinations.

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

Gender Affirming Care

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

Habilitative Services

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

Habilitative Services include:

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

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

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed Social Worker or licensed Psychologist; and
- The initial or continued treatment must not be Experimental or 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.

Hearing Aid

- We provide wearable Hearing Aids and related services to individuals up to age 18
- One Hearing Aid per hearing-impaired ear, up to $3,000 per ear every 48 months and You were verified as being deaf or hearing impaired by a licensed audiologist, otolaryngologist or other licensed physician.
- You may choose a higher priced Hearing Aid and must pay the difference in cost above the $3,000 required coverage without any financial or contractual penalty to You or to the Provider of the Hearing Aid.
- We will only provide coverage for Hearing Aids that are considered medically appropriate to meet Your needs, according to professional standards established by the state speech and hearing professionals' boards.

Home Health Care

We cover Medically Necessary home health care services that are performed by a Home Health Care Agency or other Provider in Your residence as a substitute for a Hospital stay and based on a Physician's order. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. You must be confined to the home for medical reasons and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- Medical/Social services.
- Diagnostic Services.
- Nutritional guidance.
- Home Health Aide Services. We cover the services of a home health aide when those services are part of a Physician-ordered plan of care that includes skilled medical services or therapies and is intended as a substitute for more expensive facility-based care. We do not cover long-term Custodial Care when that is the only service You need. Services performed by Home Health Care organizations or agencies require Prior Authorization.
- Therapy Services.
- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).

Non-Covered Services include but are not limited to:

- Services that are purely custodial in nature (e.g., help with bathing, dressing, or eating when that is the only care needed) or for services provided to family members, 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 services.

Hospital – Inpatient Stay

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

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

Infertility Services

We cover services for the diagnosis and treatment of the underlying medical causes of infertility when the services are provided by or under the direction of a Network Provider and are otherwise

covered under this Plan. Covered Services may include Medically Necessary evaluation, testing, and treatment of a medical condition that causes infertility, such as endometriosis, blocked fallopian tubes, varicocele, or another covered medical condition.

This benefit does not include assisted reproductive technology or services to achieve pregnancy, such as in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, donor eggs or sperm, surrogacy services, or reversal of voluntary sterilization, unless specifically covered elsewhere in this Plan or required by applicable law

Fertility Preservation Services

We provide coverage for standard fertility preservation services for a Covered Person who is scheduled to undergo a medical treatment that is expected to cause iatrogenic infertility (infertility caused by the treatment). This includes, but is not limited to, treatments for conditions such as cancer, sickle cell disease, or lupus.

Covered Services under this benefit include the evaluation, laboratory assessments, Drugs, and procedures associated with the procurement and cryopreservation (freezing) of gametes (eggs or sperm).

Limitations and Exclusions: This benefit is for fertility preservation before or during treatment that may cause iatrogenic infertility. This benefit does not include:

- The future use of stored eggs, sperm, embryos, or other reproductive material to achieve pregnancy;
- Assisted reproductive technology, including IVF, GIFT, or ZIFT;
- Donor eggs, donor sperm, donor embryos, or surrogacy-related services;
- Reversal of a voluntary sterilization procedure; or
- Services not covered under this Plan, unless required by applicable law.

Coverage is subject to this Plan's Medical Necessity requirements, Prior Authorization requirements when applicable, applicable Copayment, Deductible, and Coinsurance, Network requirements, limitations, and Exclusions.

Infusion Therapy

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

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

pain management and chemotherapy.

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

Mammography Screening

Covered Services under this benefit include preventive mammography screening and medically appropriate breast imaging services, subject to the terms and conditions of this Plan.

Coverage includes:

- An annual screening mammogram for women beginning at age 40;
- Digital breast tomosynthesis when used for screening or diagnostic purposes;
- Diagnostic mammography and other breast imaging when ordered by a Provider to evaluate signs, symptoms, abnormal screening results, or other clinical concerns; and
- Supplemental breast screening, which may include breast ultrasound, magnetic resonance imaging (MRI), or other imaging modalities, when recommended by a Provider based on clinical risk factors or guidelines recognized under applicable law.

Clinical risk factors may include, but are not limited to, a personal history of breast cancer, a family history of breast cancer in a first- or second-degree relative, positive genetic testing or known hereditary cancer risk, dense breast tissue, or other risk factors identified by Your Provider.

Coverage is subject to applicable Medical Necessity requirements, Prior Authorization requirements when applicable, the Schedule of Benefits, and all other terms, limitations, and Exclusions of this Plan 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.

Maternity Services

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

Coverage for the postpartum Inpatient stay for You and Your newborn Child in a Hospital will be, at a minimum, forty-eight (48) hours for a vaginal delivery and ninety-six (96) hours for a cesarean section. Coverage for a length of stay begins at the time of delivery, if delivery occurs in a Hospital, or at the time of admission in connection with childbirth if delivery occurs outside

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

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

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

The Plan also provides benefits for Physician or advance practice registered nurse-directed follow-up care. Covered Services for follow-up care include physical assessment of Your newborn and you, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any Medically Necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. This Benefit applies to services provided in a medical setting or through home health care visits. This Benefit will apply to a home health care visit only if the Network Provider who conducts the visit is knowledgeable and experienced in maternity and newborn care. The Plan also provides benefits for at-home post-delivery care visits by Your Physician or nurse performed no later than seventy-two (72) hours following You and Your newborn Child's discharge from the Hospital. Covered Services for at-home post-delivery care visits include but are not limited to:

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

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

Telehealth services. This is provided on the same basis and to the same extent (included Cost Shares) for the provision of in-person health care services.
- Medically Necessary services for complications arising from medical and surgical conditions.

Medical and Surgical Supplies

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

- Allergy serum extracts.
- Chem strips, Glucometer, Lancets.
- Clinitest.
- Needles/syringes.
- Medically Necessary ostomy bags and supplies, except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Exclusions:

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

- Adhesive tape, band aids, cotton tipped applicators.
- Arch supports.
- Doughnut cushions.
- Hot packs, ice bags.
- Vitamins.
- Med-injectors.
- Items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Medical Foods

We cover medical foods and formulas when Medically Necessary for the treatment of a disease or condition and prescribed by an In-Network Provider, subject to the terms, conditions, and limitations of the Plan. Covered medical foods may include enteral or parenteral nutrition, elemental or specialized formulas for malabsorption or metabolic conditions, dietary formulas for the treatment of Phenylketonuria (PKU) and other inborn errors of metabolism, and Medically Necessary pasteurized donor human milk when prescribed by a In-Network, licensed pediatric Provider. Coverage is provided when supported by a written order documenting Medical Necessity.

Morbid Obesity Treatment

We cover the surgical and non-surgical treatment of morbid obesity. Your Provider must certify that the treatment is Medically Necessary and that You meet the criteria established in the law, which includes having previously attempted a Physician-supervised diet program. All surgical procedures require Prior Authorization.

Mental Health Disorder and Substance Abuse Services

Prior Authorization is required for certain Mental Health Disorder and Substance Abuse services.

Emergency Services never require Prior Authorization. Covered Services include services for Mental Health Disorders and Substance Abuse. 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 Abuse conditions, Severe Mental Illness (SMI) of a person of any age, and Serious Emotional Disturbances (SED) of a Child as defined by the most recent edition of the DSM. We comply with applicable federal law governing mental health parity, including but not limited to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Mental health Covered Services include the following:

- Inpatient services in a licensed, Network Hospital, Residential Treatment center, or any Facility that We must cover per state law. Inpatient benefits include:
    - Inpatient Facility services for Acute mental health conditions, including Physician Services;
    - Inpatient psychiatric observation for Acute psychiatric crisis, including Physician Services, medications, and testing;
    - Residential Treatment.
- Outpatient office visits
    - Individual and group mental health evaluation and treatment;
    - Outpatient Services for monitoring Drug therapy;
    - Mental/behavioral health Outpatient Therapy Services for Autism Spectrum Disorder (See the Autism Spectrum Disorder section above).
- Outpatient Items and Services
    - Partial Hospitalization/Day Treatment;
    - Short-term intensive Outpatient psychiatric treatment;
    - Outpatient psychiatric observation for an Acute psychiatric crisis;
    - Psychological testing and neuropsychological testing to evaluate a mental condition;
    - Behavioral Health Therapy Home Visit for Autism Spectrum Disorder.
- Substance Abuse (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 Abuse;
        - Intensive Outpatient Treatment for Substance Abuse;
        - Ambulatory detoxification;
        - Non-emergency psychiatric transportation.
- Covered Services for mental health includes certain medications and testing or diagnosis covered under the medical benefit.

Inpatient services coverage includes individual psychotherapy, group psychotherapy, psychological testing, and counseling with family members to assist with the patient's diagnosis and treatment, and convulsive therapy, detoxification, and rehabilitation treatment; Hospital and

Inpatient professional charges in any Hospital or Facility required by state law.

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

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

Orthotic Devices

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

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

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

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

Outpatient Services

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

Pediatric Vision Services

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

- Vision exam – one (1) per Benefit Period. The exam is comprehensive and includes dilation, if professionally indicated.
- Prescription lenses and frames – standard prescription lenses– one (1) per Benefit Period. We will pay for one (1) standard frame per Benefit Period.
    - Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses. Polycarbonate lenses are covered in full for Children. All lenses include scratch resistant and UV coating with no additional cost.
- Prescription contact lenses – 1 item covered in full once every Benefit Period –in lieu of eyeglasses. Items include:
    - Standard (one pair annually) = 1 contact lens per eye (total 2 lenses)
    - Monthly (six-months' supply) = 6 lenses per eye (total 12 lenses)
    - Bi-weekly (three-months' supply) = 6 lenses per eye (total 12 lenses)
    - Dailies (three-months' supply) = 90 lenses per eye (total 180 lenses)
- Low Vision – Low vision is covered if vision loss is sufficient to prevent reading and performing daily activities. Coverage includes an annual low vision evaluation. Network Providers will obtain the necessary Prior Authorization for these services. We also cover low vision aids, including prescription services and optical/non-optical aids.

<u>Exclusions:</u>

The Plan does not cover:

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

- Special lens designs or coatings other than those listed as Covered Services.
- Replacement of lost or stolen eyewear.
- Non-prescription (Plano) lenses.
- Two pairs of eyeglasses in lieu of bifocals.
- Services not performed by licensed personnel.
- Prosthetic devices and services.
- Insurance of contact lenses.
- Professional services You receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption.

Preventive Care Services (Covered without Cost-Sharing)
We cover preventive care services without Cost-Sharing when they are provided by a Network Provider and are required to be covered without Cost-Sharing under applicable law. Preventive care services may include screenings, immunizations, counseling, and other services intended to prevent illness or detect health conditions early.

Covered preventive care services include, as applicable:

- Evidence-based items or services that have an “A” or “B” rating in the current recommendations of the United States Preventive Services Task Force;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings for infants, Children, and adolescents provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- Preventive care and screenings for women provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive services are covered without Deductible, Copayment, or Coinsurance when provided by a Network Provider and when billed as preventive care. If You receive non-preventive or Diagnostic services during a preventive care visit, Cost-Sharing may apply to those services.

We may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for preventive services when the applicable recommendation or guideline does not specify those details.

Preventive services may include, but are not limited to:

- Adult preventive screenings, including blood pressure screening, cholesterol screening, diabetes screening, colorectal cancer screening, depression screening, hepatitis screening, HIV screening, lung cancer screening for eligible high-risk adults, obesity screening and counseling, tobacco or nicotine use screening and cessation support, and sexually transmitted infection screening and counseling;
- Recommended adult immunizations;
- Women’s preventive services, including well-woman visits, contraceptive methods and counseling, breastfeeding support and supplies, pregnancy-related screenings, cervical cancer screening, breast cancer screening, BRCA-related risk assessment and counseling, interpersonal violence screening and counseling, and other services required under applicable guidelines;
- Children’s preventive services, including well-child visits, developmental and behavioral screenings, newborn screenings, immunizations, hearing and vision screening, oral health

risk assessment, lead screening, obesity screening and counseling, and other services required under applicable guidelines.

Breast Cancer Screening and Imaging

Coverage includes breast cancer screening and imaging services as required under applicable law and this Plan. This may include screening mammography, digital breast tomosynthesis, diagnostic breast imaging, breast ultrasound, breast MRI, or other imaging modalities when covered under this Plan and recommended based on Your age, symptoms, screening results, breast density, family history, personal history, genetic risk, or other clinical risk factors.

Diagnostic or supplemental breast imaging may be subject to Cost-Sharing unless otherwise required by applicable law or stated in the Schedule of Benefits.

Breastfeeding Support and Supplies

Coverage includes breastfeeding support, counseling, and supplies as required under applicable preventive care guidelines. This includes one breast pump per pregnancy in connection with childbirth, when ordered by or provided through a Provider or other approved supplier. For information on how to access breast pump benefits or lactation support, contact Member Services at the number on Your ID Card.

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 as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras.
- Cranial prothesis (wig) to replace hair lost as a side effect of a medical treatment and determined to be Medically Necessary.

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

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

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

Reconstructive Services

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

Covered Services include the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth

abnormalities of a newborn Child;
- Breast reconstruction resulting from a mastectomy;
- Hemangiomas, and port wine stains of the head and neck areas for Children ages 18 years or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip; and
- Cleft palate.

Rehabilitation Services

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

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

All Therapy Services must be considered Medically Necessary and may require Prior Authorization.

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

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

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

<u>Other Therapy Services</u>

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.

<u>Live Donor Health Care Services</u>

The Plan provides benefits for Medically Necessary health care services only for the procurement of an organ from a live donor. Coverage includes the:

- Evaluation Phase: Tests, lab work, imaging and consultations to determine if the potential donor is a suitable match and healthy enough to donate.
- Donor Procedure: All costs related to the donor's surgery, including the surgeon's fees, anesthesia, and the hospital stay itself.
- Post-Operative Care: All follow-up care for the donor related to the donation, including treatment for any short-term or long-term medical complications that arise from the procedure.

This coverage does not include payment or reimbursement for non-medical expenses such as the donor's travel, lodging, or lost wages.

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

Urgent Care

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

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

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

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. Your Cost-Sharing for Prescription Drugs will depend on the drug tier.

We also provide coverage for a Prescription Drug even if it is used for a different purpose than the one for which it was approved by the Food and Drug Administration ("FDA") ("off-label use"), provided that the Drug is recognized for the treatment of Your specific medical condition in one of the standard medical compendia or in peer-reviewed medical literature. This coverage is most often applicable for the treatment of cancer or other life-threatening conditions.

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.).

We update the Antidote Formulary on an ongoing basis in accordance with federal and state law.

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.

Requesting an Exception to the Antidote Formulary

We understand that in certain medical situations, a Drug that is not on the Antidote Formulary may be the most appropriate treatment for You. You or Your Provider have the right to request a "formulary exception" to obtain coverage for a non-formulary Drug. We will approve a formulary exception if Your Provider certifies that the requested drug is Medically Necessary because:

- The alternative Drug(s) on our formulary have been ineffective in treating Your condition;
- The alternative drug(s) on the Antidote Formulary have caused, or are likely to cause, an adverse or harmful reaction; or
- The requested non-formulary Drug is required for You to have a treatment regimen that is more clinically appropriate for Your specific condition than any available formulary Drug.

We will make a decision on a standard exception request within 72 hours and on an urgent request within 24 hours. If Your request is denied, You have the right to file an appeal. To start the formulary exception process, please have Your Provider contact Navitus Health Solutions at the number listed on the back of Your ID Card.
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 Evidence of Coverage. The twelve (12) month approval provided by Us will no longer be valid and will automatically terminate if there are changes to federal or state laws or federal regulatory guidance or compliance information prescribing that the Prescription Drug in question is no longer approved or safe for the intended purpose. We may require a Covered Person’s Provider to submit information to Us indicating that a Covered Person’s chronic condition has not changed. The frequency of the submission of requested information by the Plan will be consistent with medical or scientific evidence as required by law but will not be required more frequently than on a quarterly basis.

Tiers of Covered Drugs and Your Cost Share

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

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

Specialty Drugs

Drugs that require specialized patient education prior to use and ongoing patient assistance while under treatment are called Specialty Drugs. These Specialty Drugs must be dispensed through a Specialty Pharmacy. Please visit Our website at antidotehealth.com/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.

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 and Your Right to an Exception

For certain medical conditions, We may require You to try a safe and effective preferred Drug before We will cover a different, non-preferred Drug. This is known as a step therapy protocol.

You or Your Provider may request an exception to a step therapy protocol. We will grant an

exception when the required information supports that the preferred Drug is not appropriate for You. This may include situations where:

- The preferred Drug is contraindicated or is likely to cause an adverse reaction or physical or mental harm;
- The preferred Drug is expected to be ineffective based on Your clinical condition or the known characteristics of the Drug;
- You have already tried the preferred Drug, or another Drug in the same pharmacological class or with the same mechanism of action, and it was discontinued due to lack of effectiveness, diminished effect, or an adverse event; or
- You are currently receiving a positive therapeutic outcome on another Drug for the same medical condition, and changing to the preferred Drug is expected to be ineffective or cause harm.

Once We receive a complete step therapy exception request, We will make a decision within the timeframe required by applicable law. We will decide urgent requests within twenty-four (24) hours and nonurgent requests within two (2) business days. If We do not respond within the required timeframe, the exception will be deemed approved as required by law.

If the exception is approved, We will authorize coverage for the Drug prescribed by Your Provider, provided the Drug is covered under this Plan. If the exception is denied, You or Your Provider may appeal the decision. 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 Abuse conditions. 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.

Opioid Medications and Treatment

We cover Medically Necessary services and medications for the treatment of pain and substance use disorders, including Opioid Use Disorder, in accordance with this Plan, applicable law, the formulary, and Medical Necessity requirements.

Certain opioid medications may be subject to safety edits, quantity limits, Prior Authorization, step therapy, or other utilization management requirements when permitted by applicable law. These requirements are intended to support safe and appropriate use of opioid medications.

We cover treatment for Opioid Use Disorder, including FDA-approved medications for opioid use disorder (MOUD), when covered under this Plan and prescribed by an authorized Provider. Coverage may include medications such as buprenorphine, naltrexone, or other covered medications, as clinically appropriate and consistent with the formulary and applicable law.

Naloxone or other opioid overdose reversal medications may be covered under this Plan when prescribed or dispensed in accordance with applicable law and Plan requirements.

In certain situations, We may use a patient safety review process for controlled substances when permitted by applicable law. This process may include care coordination, pharmacy review, prescriber outreach, or other safety measures to help reduce the risk of harm, duplication, or misuse. Any Adverse Benefit Determination related to this process will include information about Your appeal rights.

Anticancer Medications (Chemotherapy Parity)

We cover Medically Necessary anticancer medications in accordance with this Plan, including applicable formulary, Medical Necessity, Prior Authorization, and benefit requirements.

When this Plan covers intravenously administered or injected chemotherapy for the treatment of cancer, We will cover orally administered chemotherapy for the treatment of cancer on a basis no less favorable than intravenously administered or injected chemotherapy, as required by applicable law.

Your Cost-Sharing for orally administered chemotherapy will be determined in accordance with this Plan and applicable law. We will not increase Cost-Sharing for intravenously administered or injected chemotherapy in order to achieve compliance with oral chemotherapy parity requirements.

Your Right to Request a Formulary Exception

If a Prescription Drug is not on the Formulary, You, Your Authorized Representative, or Your licensed Provider may request a Formulary exception. A Formulary exception may be requested when Your Provider determines that a non-Formulary Drug is Medically Necessary for You.

A Formulary exception may be appropriate when, for example:

- You have had a positive therapeutic outcome with the requested Drug;
- Formulary alternatives may cause an adverse reaction or harmful interaction;
- Formulary alternatives are not medically appropriate for Your condition; or
- Formulary alternatives are expected to be ineffective based on Your clinical history or condition.

A Formulary Exception Request Form is available from Navitus Health Solutions, Our pharmacy benefit manager. Your Provider may request the form by calling Navitus at **888-836-5146** or **TTY 711**, 24 hours a day, 7 days a week. The form is also available at **antidotehealth.com/forms**.

Standard Formulary Exception Requests
For standard Formulary exception requests, Navitus will notify You and Your Provider of Our determination no later than seventy-two (72) hours after receiving the request and supporting clinical documentation.

If a standard Formulary exception request is approved, coverage will be provided for the duration of the prescription, including refills, or as otherwise required by applicable law and this Plan.

Urgent Formulary Exception Requests
You or Your Provider may request an urgent Formulary exception when a delay could seriously jeopardize Your life or health, affect Your ability to regain maximum function, or when You are undergoing a current course of treatment using the non-Formulary Drug.

For urgent Formulary exception requests, Navitus will notify You and Your Provider of Our determination no later than twenty-four (24) hours after receiving the request and supporting clinical documentation.

If an urgent Formulary exception request is approved, coverage will be provided for the duration of the urgent circumstance, or as otherwise required by applicable law and this Plan.

Approval or Denial of Formulary Exception Requests

If Your Formulary exception request is approved, You may be responsible for the applicable Cost-Sharing for the approved Drug, as described in this Plan.

If Your Formulary exception request is denied, You and Your Provider will receive written or electronic notice of the denial, including the medical or pharmacological reason for the denial and information about Your appeal or external review rights.

External Review of Denied Formulary Exception Requests

If We deny a standard Formulary exception request, You, Your Authorized Representative, or Your Provider may request external review of the denial. The external reviewer will provide a determination no later than seventy-two (72) hours after receiving the external review request and supporting clinical documentation.

If We deny an urgent Formulary exception request, You, Your Authorized Representative, or Your Provider may request expedited external review. The external reviewer will provide a determination no later than twenty-four (24) hours after receiving the expedited external review request and supporting clinical documentation.

Negative Formulary Changes

Negative Formulary changes may include removing a Drug from the Formulary, moving a Drug to a higher Cost-Sharing tier, or adding or increasing utilization management requirements such as Prior Authorization, Step Therapy, or Quantity Limits.

Negative Formulary changes are reviewed through the Pharmacy and Therapeutics process before

implementation, except when a change is made for reasons such as safety, FDA recall, FDA warning, availability of an equivalent generic or equivalent chemical entity at an equal or lower Cost-Sharing tier, or another reason permitted by applicable law.

If a Negative Formulary change affects a Drug You are taking, Navitus Health Solutions will notify You in advance when required by applicable law or Plan procedures.

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 Experimental or Investigational 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, such as Tretinoin, unless determined to be Medically Necessary.

- 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 performed for a Covered Person by a Covered Person's immediate family.
- Any services not identified and included as Covered Service expenses under the contract. You will be fully responsible for payment for any services that are not Covered Service expenses.

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

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

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

- For services or supplies that are provided prior to the Effective Date or after the termination date of this contract, except as expressly provided for under the contract's TERMINATION section.
- For any portion of the charges that are in excess of the eligible service expense.
- For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery except as specifically mentioned in the Covered Health Care Services section of this contract.
- For cosmetic breast reduction or augmentation.
- For the reversal of sterilization and vasectomies.
- For non-therapeutic abortion.
- For expenses for television, telephone, or expenses for other persons.
- For marriage, family, or Child counseling for the treatment of premarital, marriage, family, or Child relationship dysfunctions.
- For telephone consultations, except those meeting the definition of Telehealth services, or for failure to keep a scheduled appointment.
- For dental service expenses, including braces for any medical or dental condition, surgery, and treatment for oral surgery, except as expressly provided for under the Accidental Dental benefits.
- For cosmetic treatment, except for Medically Necessary reconstructive surgery that is incidental to or follows surgery or an injury or is performed to correct a birth defect.
- For diagnosis or treatment of learning disabilities.
- For diagnosis or treatment of nicotine addiction, except as expressly provided

for under Preventive Care Services.

- For eye refractive surgery when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
- While confined primarily to receive rehabilitation, Custodial Care, educational care, or nursing services (unless expressly provided for in this contract).
- For vocational or recreational therapy, vocational rehabilitation, Outpatient speech therapy, or occupational therapy, except as expressly provided for in this contract.
- For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
- For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this EOC.
- For Hearing Aid or assistive listening device batteries, including rechargeable batteries, any size and Hearing Aid or assistive listening device cords except as expressly provided in this EOC.
- 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 Abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan.
- For treatment received outside the United States, except for Emergency Services while traveling for up to a maximum of ninety (90) consecutive days.
- As a result of an injury, disease, defect, or ailment arising out of and in the course of employment for wage or profit, if the Covered Person is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If workers' compensation insurance is not available to You, then this exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether You claim the benefits or compensation. It also applies whether 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 IX – TERMINATION

The initial term of this Evidence of Coverage commences on the Evidence of Coverage Effective Date and continues through the Benefit Period. This Evidence of Coverage shall automatically be renewed thereafter from year-to-year, unless sooner terminated by the Policyholder or Us as set forth below.

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

As more fully described below, We may terminate Your coverage only for the following reasons, and only after providing You with the required advance written notice:

- Non-payment of Premiums: Subject to the applicable Grace Period described below. We will provide you with 10 days advance written notice before terminating for non-payment.

- Fraud or Intentional Misrepresentation of a Material Fact: We will provide You with 45 days advance written notice before terminating for this reason.

- Loss of Eligibility: You cease to be eligible for coverage under the terms of the plan (e.g., You no longer reside in the Plan's service area). We will provide you with 45 days advance written notice.

- Discontinuation of the Plan: We elect to discontinue offering this particular plan or all coverage in the individual market. We will provide you with at least 180 days advance written notice.

Termination of Coverage

Your right to benefits under this Plan generally ends on the date your coverage terminates. The Plan will not pay for any charges incurred for services received after your termination date, except as described below in the "Extension of Benefits" provision.

Extension of Benefits for Total Disability

If your coverage terminates for any reason while you are totally disabled due to an injury or sickness, this Plan will continue to provide benefits only for that specific, disabling injury or sickness. This extension of benefits will continue until the first of the following occurs:

- You are no longer Totally Disabled;
- The maximum benefit for the condition as listed in Your Schedule of Benefits has been paid; or
- A period of 90 days has passed since Your termination date.

This provision ensures that your care for a disabling condition is not immediately cut off on the day your policy ends. No benefits are available under this provision for any other medical condition or for any new condition that arises after your termination date.

Grace Period for Non-Payment of Premiums

If You **DO NOT** receive an Advance Premium Tax Credit ("APTC" or sometimes referred to as or Cost-Sharing reduction subsidy):

- You have a Grace Period of 31 days from the Premium due date. Your coverage will remain in effect during this time, but if You do not pay Your full outstanding premium by the end of the 31-day Grace Period, Your coverage will terminate effective the last day of the month for which a full premium was paid.

If You **DO** receive an APTC and have paid at least one full month's premium (also referred to as Your binder payment):

- You have a Grace Period of three (3) consecutive months.
    - First Month: We will continue to pay claims for Covered Services submitted during the first month of the Grace Period.
    - Second and Third Months: We will pend (hold) claims for services you receive during the second and third months. We will notify You and Your Providers that claims may be denied if You do not pay Your full outstanding Premium.
    - End of Grace Period: If You pay Your full outstanding Premium before the end of the three-month period, We will pay all pended claims. If You fail to pay, Your coverage will terminate effective the last day of the first month of the Grace Period, and We will deny all pended claims from the second and third months. **You will be responsible for the cost of those services.** 45 C.F.R. § 156.270(d)

Grace Period vs. Extension of Benefits

It is critical that You understand the difference between using Your Grace Period to keep Your coverage and qualifying for an extension of benefits after Your coverage has ended.

- The Grace Period is Your window of time to pay Your outstanding Premium and prevent Your policy from terminating. If You pay in full during this period, Your coverage is reinstated with all benefits intact.

- The extension of benefits only applies after Your Grace Period has expired and Your policy has already been terminated. It is a legally required, limited safety net that covers only the specific condition that caused You to be Totally Disabled at the time of termination.

Once Your policy has terminated, it cannot be reinstated by a late Premium payment. The extension of benefits provision does not grant You the right to pay a Premium to reactivate Your full health coverage.

When Your coverage ends, We will still pay claims for Covered Services for health care that You received before the date Your coverage ended. However, once Your coverage ends, unless You are Totally Disabled, 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

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

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

  We will provide at least forty-five (45) days advance required notice to the Policyholder that coverage will end on the date We identify in the notice because

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

- **You Accept Reimbursement for Premium**

  You accept any direct or indirect contribution or reimbursement by or on behalf of any third party including, but not limited to, any Health Care Provider or any Health Care Provider sponsored organization for any portion of the Premium for coverage under this Plan. This prohibition does not apply to the following third parties:

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

Reinstatement

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

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

Refunds after Termination

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

Health Status

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

Continuation

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

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

SECTION X – COST-SHARING AND PAYMENT OBLIGATIONS

As a Member, You are responsible for paying Your monthly premium, as applicable, and any required Cost-Sharing for the Covered Services You receive. Cost-Sharing includes your Deductible, Copayments, and Coinsurance.

Eligible Expenses

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

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

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

Allowed Amount

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

Review the definition of Allowed Amount in the DEFINITIONS section of this Plan to

understand the guidelines used by Us.

Deductibles

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

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

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

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

Copayment Amounts

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

Coinsurance Amounts

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

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

Maximum Out-of-Pocket

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

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

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

Family Maximum Out-of-Pocket

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

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

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

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

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

Hold Harmless and Balance Billing

Your In-Network Provider will bill Us directly for Covered Services. You are only responsible for paying Your applicable Deductible, Copayment, or Coinsurance amounts directly to the In-Network provider.

No Balance Billing by In-Network Providers:

As required by Georgia law and their contract with Us, In-Network Providers are prohibited from “balance billing” you. This means they cannot bill you for the difference between their full charge and Our allowed amount for a Covered Service. Your Cost-Sharing amount is Your only financial responsibility to an In-Network Provider for Covered Services.

Payment of Premiums

Payment of monthly Premiums for coverage under this Plan shall be made by You or a third party listed below. Premiums shall be remitted on a monthly basis to Us within the specified time frames set forth in this Plan. Only a Covered Person for whom the Premium is actually received by Us, who has met all other applicable provisions of this Plan, and who has been accepted by Us, shall be entitled to coverage under this Plan and only for the month for which such Premium is received except with respect to

newborn Child coverage, which is automatically provided under this Plan for the first thirty-one (31) days.

We only accept Premium payments from the following third parties:

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

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

Adjustment of Premiums

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

Misrepresentation Regarding Tobacco Use

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

SECTION XI – PRIOR AUTHORIZATION

Prior Authorization

Some services and items require Prior Authorization before they are provided. Prior Authorization is the process We use to determine, based on the information submitted, whether a requested health care service or item meets this Plan's requirements for coverage, Medical Necessity, appropriateness, level of care, treatment setting, and other applicable Plan requirements.

Your Network Provider is responsible for requesting Prior Authorization from Us when Prior Authorization is required. You may also contact Member Services to ask whether a service or item requires Prior Authorization. The Prior Authorization list is available by calling Member Services at 888-623-3195 or by visiting antidotehealth.com/plandocs.

Prior Authorization is not required for Emergency Services. Except as otherwise provided

under this Plan or required by applicable law, services provided by an Out-of-Network Provider are not covered unless We approve the services in advance. If covered services are not available from a Network Provider, We may authorize services from an Out-of-Network Provider at the In-Network benefit level.

Prior Authorization is not a guarantee of payment. Payment remains subject to Your eligibility on the date services are provided, covered benefits, Plan limitations and Exclusions, Cost-Sharing, coordination of benefits, timely claim submission, and other applicable requirements of this Plan.

Prior Authorization Decision Timelines

We will decide and notify You and Your Provider within the following timeframes:

- Urgent Pre-service Requests: For situations where a delay could jeopardize Your life, health, or ability to regain maximum function, We will decide no later than 72 hours after We receive the request.

- Standard Pre-service Requests: For all other requests for services You have not yet received, We will decide no later than two business days after We receive all necessary information from Your Provider.

If We fail to meet these timelines, the Prior Authorization request is deemed to have been granted.

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

- At least five 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 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 an Adverse Determination related to a pre-service request or concurrent review request, Your treating Provider or the Facility rendering the service may request reconsideration of the decision on Your behalf. A request for reconsideration may be made by telephone, in writing, or electronically, in accordance with Our procedures.

Reconsideration gives Your treating Provider or Facility an opportunity to discuss the Adverse Determination with the clinical reviewer who made the decision, or with another appropriate clinical reviewer if the original reviewer is not available.

Reconsideration will be completed promptly. For Urgent Care requests, reconsideration will be handled as quickly as Your medical condition requires.

Reconsideration is not required before You file an appeal. Additional information about appeals is available in Section XIII – Appeals and Complaint Procedures

SECTION XIII – APPEALS AND COMPLAINT PROCEDURES

Call Member Services

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

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

Grievance Procedure

If you have a complaint about the quality of care, customer service, or other non-benefit related aspects of Our Plan, You can file a complaint with us, also known as a grievance. A grievance is not a request to review a denial of benefits.

If You have a Grievance, please contact Us by calling Member Services or by sending it in writing. We will investigate, work to resolve, and respond in writing to Your Grievance within thirty (30) days of Our receipt of the Grievance.

Appeals

The appeals process allows You or Your Authorized Representative to request review of an Adverse Benefit Determination. This process is separate from the Grievance process described above.

You may request reasonable access to, and copies of, documents, records, and other information relevant to Your claim. You may also submit written comments, documents, records, and other information for Us to consider. If We consider new or additional evidence or a new or additional rationale during the appeal, We will provide it to You as required and give You an opportunity to respond.

Internal Appeal Process

You have the right to file an Internal Appeal if You disagree with an Adverse Benefit Determination made by Us. You or Your Authorized Representative must submit the Internal Appeal within one hundred eighty (180) days after You receive notice of the Adverse Benefit Determination. We can request supporting documentation if necessary during Our review.

Internal Appeals must be submitted in writing, except that an appeal involving Urgent Care may be requested orally or electronically. You or Your Authorized Representative may submit a written Internal Appeal to:

Antidote Health Plan of Georgia, Inc.
Attention: [Insert Department or Address]
Fax: [Insert Fax Number]
Expedited Fax: [Insert Expedited Fax Number]
Phone: The toll-free number on Your ID Card

We will review Your appeal and notify You of Our decision within the following timeframes:

- **Urgent Care Appeals:** As soon as Your medical condition requires, but no later than seventy-two (72) hours after We receive the appeal.
- **Standard Pre-Service Appeals:** No later than thirty (30) calendar days after We receive the appeal.
- **Post-Service Appeals:** No later than sixty (60) calendar days after We receive the appeal.

Expedited Internal Appeal

You may request an expedited Internal Appeal when the requested service involves a situation where the standard appeal timeframe could seriously jeopardize Your life or health, jeopardize Your ability to regain maximum function, or subject You to severe pain that cannot be adequately managed without the requested care.

You may request an expedited appeal by phone, electronically, or in writing. We will make a decision as soon as Your medical condition requires, but no later than seventy-two (72) hours after We receive the appeal. We will notify You and, when applicable, Your Authorized Representative of the decision External Appeal.

If You are not satisfied with the outcome of Your Internal Appeal, You or Your Authorized Representative may request external review by an Independent Review Organization or through another external review process available under applicable law.

External review may be available for Adverse Benefit Determinations involving Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, Experimental or Investigational services, or other matters eligible for external review under applicable law.

An external review decision is binding on Us, except to the extent other remedies may be available under applicable federal or state law. We will pay the cost of the external review. You or Your Authorized Representative must request external review within four (4) months after receiving notice of the Final Internal Adverse Benefit Determination, unless a different timeframe applies under applicable law.

Requests for standard external review must be submitted in writing. Requests for expedited external review may be submitted orally, electronically, or in writing when the standard timeframe could seriously jeopardize Your life or health, jeopardize Your ability to regain

maximum function, or when the decision involves an admission, availability of care, continued stay, or health care service for which You received Emergency Services and have not been discharged from the facility.

For a standard external review, the Independent Review Organization will provide written notice of its decision within the timeframe required by applicable law. For an expedited external review, the Independent Review Organization will provide a decision as quickly as Your medical condition requires, but no later than seventy-two (72) hours after it receives the expedited request.

Antidote Health Plan of Georgia, Inc.
[Address]
[Phone number/TDD/TTY] [Fax]

Maximus Federal Services:
State Appeals East
3750 Monroe Avenue, Suite 708
Pittsford, NY 14534
Phone: 1-888-975-1080
Fax: 1-888-866-6190

Urgent/Expedited External Appeal

You or Your Authorized Representative may request an expedited External Review when the standard External Review timeframe could seriously jeopardize Your life or health, jeopardize Your ability to regain maximum function, or when the request concerns an admission, availability of care, continued stay, or health care service for which You received Emergency Services and have not been discharged from the Facility.

An expedited External Review request may be submitted orally, electronically, or in writing. The Independent Review Organization will provide a decision as soon as possible based on the medical urgency of Your condition, but no later than seventy-two (72) hours after receiving the expedited request, or sooner if required by applicable law

Non-Urgent Request for an External Appeal

Unless the request qualifies for an urgent or expedited External Review, We will complete a preliminary review of Your External Review request within five (5) business days after We receive it to determine whether the request is complete and eligible for External Review.

Within one (1) business day after completing the preliminary review, We will notify You in writing whether the request is eligible for External Review. If the request is eligible, the External Review will be assigned to an Independent Review Organization.

The Independent Review Organization will notify You that the request has been accepted and will provide instructions for submitting additional information. You may submit additional written information to the Independent Review Organization within ten (10) business days after You receive that notice.

We will provide the Independent Review Organization with the documents and information considered in making the Adverse Benefit Determination or Final Internal

Adverse Benefit Determination within five (5) business days after the Independent Review Organization is assigned.

The Independent Review Organization will provide written notice of its final External Review decision as soon as possible, but no later than forty-five (45) days after the Independent Review Organization receives the request for External Review, unless a shorter timeframe applies under applicable law External Reviews for Experimental or Investigational Services

You or Your Authorized Representative may request an External Review when We deny coverage for a health care service because We determine that the service is Experimental or Investigational, unless the service is specifically excluded under this Evidence of Coverage.

To request External Review for an Experimental or Investigational Service, Your treating Physician must certify that at least one of the following applies:

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

An External Review for an Experimental or Investigational Service may be handled as a standard or expedited External Review, depending on the medical urgency of Your condition and applicable law.