ANTIDOTE

Antidote Health Plan of Texas, Inc.

Individual Medical EPO Outline of Coverage

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

Effective Date: January 1, 2027

## NOTICE

This is an individual Exclusive Provider Organization (EPO) Plan issued by Antidote.

PLEASE CAREFULLY READ AND REVIEW THE ENTIRE POLICY.

This Outline of Coverage (OOC) is a summary of Your health Plan benefits. It is not an insurance contract. The Policy, 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 Policy, the Policy 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.

# ANTIDOTE CONTACT INFORMATION

| Resource | Contact Information | Hours |
|---|---|---|
| Member Services Helpline | 888-623-3195 | Monday – Friday<br>7:00 AM to 1:00 AM<br>Saturday and Sunday<br>8:00 AM to 1:00 AM |
| | | |
| Urgent Care Helpline<br><br>To assist you in locating an urgent care network provider, you may call our urgent care helpline. Urgent care services received from a network provider do not require prior authorization.<br>If You have any questions regarding urgent care, please call our urgent care helpline. | 888-623-3195 | Monday – Friday<br>7:00 AM to 1:00 AM<br>Saturday and Sunday<br>8:00 AM to 1:00 AM |
| | | |
| Website | antidotehealth.com | 24 hours a day<br>7 days a week |
| | | |
| Mailing Address | [1460 Broadway<br>New York, NY 10036] | 24 hours a day<br>7 days a week |
| | | |
| **Texas Department of Insurance**<br><br>If you need assistance or wish to file a complaint | Phone:1-800-252-3439<br>Website: www.tdi.texas.gov<br>Email: ConsumerProtection@tdi.texas.gov | |
| | | |

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

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

# COVERED HEALTH CARE SERVICES

Your Plan provides all Basic Health Care Services required under Texas law, including the services described below. Covered Services are described below and appear in alphabetical order to make it easier to find what you're looking for.

**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.

**Acquired Brain Injury**

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

Treatment for an Acquired Brain Injury may be provided at a Hospital, an Acute or post-Acute Rehabilitation Hospital, an assisted living facility or any other Facility at which appropriate services or therapies may be provided.

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

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

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

**Ambulance Services**

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

- From an Out-of-Network Hospital to the closest Network Hospital when Covered Services are required.
- To the closest Network Hospital that provides the required Covered Services that were not available at the original Hospital.

- From a short-term Acute care Facility to the closest Network long-term Acute care Facility (LTAC), Network Inpatient rehabilitation Facility, or other Network sub-Acute Facility where the required Covered Services can be delivered.

**Autism Spectrum Disorder**

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

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

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

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

**Behavioral Health Care Services**

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

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

Residential Treatment Services. The Plan provides benefits for Behavioral Health Care Services in a Residential Treatment program. These Covered Services can include individual and group psychotherapy, family counseling, nursing services, and

pharmacological therapy in a congregate living community with twenty-four (24) hour support.

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

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

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

Other Outpatient Services. The Plan provides benefits for office-based Behavioral Health Care Services. These include Diagnostic evaluation, screening, testing and assessments, counseling, individual psychotherapy, group psychotherapy, family psychotherapy, psychiatry, and crisis services.

Coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations, including Deductibles, Copayments, and Cost Share

Percentage provisions that are less favorable than the limitations that apply to a physical sickness.

**Biomarker Testing**

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

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

**Chiropractic and Osteopathic Services**

Diagnostic and treatment services 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 furnished for the diagnosis or treatment of a neuromusculoskeletal condition associated with an Injury or illness. Coverage includes examinations, adjustments, and manipulation by manual or mechanical means, and adjunctive physiotherapy.

**Clinical Trials**

Benefits are available under the Plan for services for Routine Patient Care Costs that are Medically Necessary and rendered as part of an approved clinical trial if the services are otherwise Covered Services under the Plan. The treatment being provided must be part of a study being conducted in accordance with a clinical trial approved.

**Cochlear Implants**

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

Covered Services Include:

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

Benefit Limitations:

- Implants: Coverage is limited to one (1) Cochlear Implant per ear.

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

**Dialysis**

Medically Necessary Acute and chronic dialysis services are covered benefits unless other coverage is primary, such as Medicare for dialysis. There are two types of treatment: hemodialysis and peritoneal dialysis. You may receive hemodialysis in an In-Network Dialysis Facility or peritoneal dialysis in Your home from a Network Provider when You qualify for home dialysis. Covered expenses include:

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

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

**Diagnostic Services**

The Plan provides benefits for non-invasive Diagnostic Services. 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.

Coverage is for standard equipment only. We cover the cost of repair or replacement when made necessary by normal wear and tear.

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

**Early Detection Tests for Cardiovascular Disease**

Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when

performed by a laboratory that is certified by a recognized national organization:

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

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

**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.
- Vasectomy and services related to this procedure.

**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.

**Developmental Delay Therapy for Children Ages 2–6**

Plan also covers Rehabilitative and Habilitative Services for a Child age 2 through 6 who has been diagnosed with a developmental delay or pervasive developmental disorder. Covered Services include physical therapy, occupational therapy, speech therapy and other Medically Necessary therapies that are part of a treatment plan to promote age appropriate development or improve functional skills. These services are covered on the same basis as other Habilitative Services.

**Hearing Aids**

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

- Covered Services Include:

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

- Benefit Limitations:

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

**Home Health Care**

We cover services that are performed by a Home Health Care Agency or other Provider in Your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. Services must be prescribed by the attending Physician as part of a treatment plan, and the attending Physician must certify that Hospitalization or confinement in a Skilled Nursing Facility would be required if Home Health Care was not provided. Services must be Medically Necessary.

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

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

**Hospital – Inpatient Stay**

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

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

**Infertility Services**

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

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

Covered fertility preservation services include collection and preservation of sperm, unfertilized oocytes (eggs) and ovarian tissue. Coverage does not include storage of sperm, oocytes or ovarian tissue.

**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. 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.

We also cover Chimeric Antigen Receptor (CAR) T-cell therapy when Medically Necessary and administered by a Network Provider. Provider must be qualified as a certified health care facility in accordance with the procedure for CAR T-cell therapy approved by the FDA.

Note: For Specialty Drugs prescribed by a Network Provider, Prior Authorization is required if the cost of the Specialty Drug exceeds $250. Depending upon the prescribed Specialty Drug, You may be contacted by Case Management to discuss alternative Drugs and sites of care for Your infusion therapy.

**Mammography Screening**

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

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

**Mastectomy Benefits**

Covered Service expenses for a mastectomy include reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

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

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

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

**Maternity Services**

The Plan provides benefits for Maternity Services. Maternity Services include Inpatient services, Outpatient Services, Physician home visits and office services. These services

are used for normal or Complications of Pregnancy, miscarriage, Therapeutic Abortion, and ordinary routine nursery care for a healthy newborn.

Coverage 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.

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

The Plan also provides benefits for Physician or advance practice registered nurse-directed follow-up care. Covered Services for follow-up care include physical assessment of Your newborn and you, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any Medically Necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

This Benefit applies to services provided in a medical setting or through Home Health Care visits. 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.

**Medical and Surgical Supplies**

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

**Medical Foods**

**Amino Acid-Based Elemental Formulas**

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

- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- Severe food protein-induced enterocolitis syndromes;
- Eosinophilic disorders, as evidenced by the results of biopsy; and

- Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

**Mental Health Condition and Substance Use Services**

Covered Services include services for Mental Health Conditions and Substance Use. Deductible, Copayment or Cost Share Percentage amounts, quantitative treatment limitations and nonquantitative treatment limitations applicable for covered Mental Health Conditions and Substance Use will be applied in the same manner, and no more restrictively than those applied to medical and surgical health benefits. This includes services for all mental conditions identified as "Mental Disorders" in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including the diagnosis and Medically Necessary treatment of Substance Use, Severe Mental Illness (SMI) of a person of any age, and Serious Emotional Disturbances (SED) of a Child as defined by the most recent edition of the DSM. We comply with applicable federal and Texas laws governing mental health parity, including but not limited to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Mental health Covered Services include the following:

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

    - Outpatient Items and Services
        - Day treatment program for Substance Use;
        - Intensive Outpatient Treatment for Substance Use;
        - Ambulatory detoxification;
        - Non-emergency psychiatric transportation.
- Covered Services for mental health includes certain medications and testing or diagnosis covered under the medical benefit.

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

Outpatient services coverage includes diagnosis and treatment of psychiatric conditions, individual and group psychotherapy, psychological testing, office visits, Outpatient Facility and Physician charges, and medication management checks.

**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.

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

**Outpatient Services**

The Plan provides benefits for Outpatient Services. Outpatient Services include Facility, ancillary, Facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider (including an Ambulatory Surgical Center) as determined by the Plan. These Facilities may include a non-Hospital site providing Physician services, Diagnostic Services, Therapy Services, surgery, rehabilitation, therapeutic radiology, Home Health Care, preventive, Mental Health Conditions, Emergency Services or other Provider Facility as determined by us.

**Physician-Administered Drugs**

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

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

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

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

**Preventive Care Services** (Covered without Cost-Sharing)

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

How billing works: Preventive services are covered at no cost to You when provided by a Network Provider and when the service is recommended for Your age and situation. If You receive other non-preventive services during the same visit, Cost-Sharing may apply to those additional services.

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, Children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
    - Contraceptive devices, including the insertion or removal of, and any Medically Necessary consultations, examinations, or procedures

associated with, the use of intrauterine devices, diaphragms, injectable contraceptives, and implanted hormonal contraceptives.
    - Benefits include preventive mammography screening and Diagnostic imaging performed on dedicated equipment for diagnostic purposes, including digital breast tomosynthesis, magnetic resonance imaging, ultrasound or other modality at such age and intervals as recommended by the national comprehensive cancer network and in accordance with state law. This includes patients at risk for breast cancer who have a family history with one or more first or second degree relative with breast cancer, prior diagnosis of breast cancer, positive testing for hereditary gene mutations or dense breast tissue based on the breast imaging reporting and data system of the American College of Radiology.
- Screening for nicotine or tobacco use; and
- For those who use nicotine or tobacco products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
    - Four (4) nicotine or tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling, and individual counseling) without Prior Authorization; and
    - All Food and Drug Administration (FDA) approved nicotine or tobacco cessation medications (including both prescription and over-the-counter medications) for a ninety (90) day treatment regimen when prescribed by a healthcare Provider without Prior Authorization.

Benefits defined under the Health Resources and Services Administration (HRSA) requirement include one breast pump per pregnancy in conjunction with childbirth. Breast pumps need to be ordered by or provided by a Physician. Prenatal and postnatal lactation support and counseling from In-Network obstetricians and Providers are also included.

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

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

Covered Preventive Services for Adults include:

- Abdominal Aortic Aneurysm one-time screening for adults of specified ages who have ever smoked;
- Alcohol misuse screening and counseling;
- Aspirin used to prevent cardiovascular disease for adults of certain ages;
- Blood pressure screening for all adults;
- Cholesterol screening for adults of certain ages or at higher risk;
- Colorectal Cancer screening for adults age 45 and over, including a Medically Necessary follow-up screening after an initial abnormal screening test or

procedure, as required by applicable law;

- Prostate Cancer exam for men over 50 or men over 40 with a family history of prostate cancer or prostate cancer risk factors.
- Depression screening for adults;
- Type 2 Diabetes screening for adults with high blood pressure;
- Diet counseling for adults at higher risk for chronic disease;
- Hepatitis B screening for adults at high risk, including adults from countries with 2% or more Hepatitis B prevalence, and U.S.-born adults not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence;
- Periodic health evaluation for each adult, which includes a health risk assessment at least once every three (3) years;
- Hepatitis C screening for adults at increased risk, and one time for adults age 18-79;
- HIV screening for all adults at higher risk and medically appropriate HIV pre-exposure prophylaxis (PrEP) and related services to the extent those ancillary services are classified as Preventive Care under the Affordable Care Act.
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Diphtheria;
    - Hepatitis A;
    - Hepatitis B;
    - Herpes Zoster;
    - Human Papillomavirus;
    - Influenza (Flu Shot);
    - COVID-19;
    - Measles, Mumps, Rubella;
    - Meningococcal;
    - Pneumococcal;
    - Tetanus, Diphtheria, Pertussis; and
    - Varicella.
- Lung cancer screening for adults 50-80 at high risk for lung cancer because the adult is a heavy smoker or has quit in the past fifteen (15) years;
- Obesity screening and counseling for all adults;
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
- Tobacco or nicotine use screening for all adults and cessation interventions for tobacco or nicotine users; and
- Syphilis screening for all adults at higher risk.

Covered Preventive Services for Women and Pregnant Women include:

- Anemia screening on a routine basis for pregnant Covered Persons;
- Urinary tract or other infection screening for pregnant Covered Person;
- BRCA counseling about genetic testing for Covered Persons at higher risk;
- One (1) cytologic screening per year or more often if recommended by a Physician;

- Preventive mammography screening and Diagnostic imaging performed on dedicated equipment for diagnostic purposes by a Covered Person's Physician, subject to all the terms and conditions of this Policy, including:
    - A mammogram
    - Digital breast tomosynthesis, magnetic resonance imaging, ultrasound or other modality and at such age and intervals as recommended by the national comprehensive cancer network. This includes patients at risk for breast cancer who have a family history with one or more first or second degree relatives with breast cancer, prior diagnosis of breast cancer, positive testing for hereditary gene mutations or heterogeneously or dense breast tissue based on the breast imaging reporting and data system of the American College Of Radiology;
- Breast cancer chemoprevention counseling for Covered Persons at higher risk;
- Breastfeeding comprehensive support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing Covered Persons;
- Cervical cancer screening;
- Chlamydia infection screening for younger Covered Persons and other Covered Persons at higher risk;
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a Health Care Provider for Covered Persons with reproductive capacity (not including abortifacient Drugs);
- Domestic and interpersonal violence screening and counseling for all Covered Persons;
- Folic acid supplements for Covered Persons who may become pregnant;
- Gestational diabetes screening for Covered Persons 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
- Gonorrhea screening for all Covered Persons at higher risk;
- Hepatitis B screening for pregnant Covered Persons at their first prenatal visit;
- Prenatal vitamins;
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active Covered Persons;
- FDA-approved Human Papillomavirus (HPV) Test;
- Coverage for Medically Necessary bone mass measurement and for diagnosis and treatment of osteoporosis;
- Rh Incompatibility screening for all pregnant Covered Persons and follow-up testing for Covered Persons at higher risk;
- Tobacco or nicotine use screening and interventions for all Covered Persons, and expanded counseling for pregnant tobacco users;
- Sexually Transmitted Infections (STI) counseling for sexually active Covered Persons;
- CA-125 blood test;
- Syphilis screening for all pregnant Covered Persons or other Covered Persons at increased risk;
- Annual preventive visit to support ongoing health needs; and
- Wellness visits to obtain recommended preventive services.

Covered Preventive Services for Children include:

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

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

**Prosthetic Devices**

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

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears, and nose.
- Breast prosthesis and wigs as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras.

Benefits are provided only for external prosthetic devices. Internal prosthetics are a Covered Service for which benefits are available under the applicable medical/surgical Covered Service categories in the 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 needs to 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.

Rehabilitation Services that Your Provider determines is Medically Necessary will not be denied, limited, or terminated if the service or therapy meets or exceeds Your treatment goals.

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

Benefits are limited to the maximum number of visits listed on Your Schedule of Benefits. The Outpatient Rehabilitation Services benefit limits described on Your Schedule of Benefits do not apply to Therapy Services provided for the treatment of a Mental Health Condition, including Autism Spectrum Disorder, or for the treatment of Substance Use. These limits also do not apply to Inpatient Rehabilitation Services or Rehabilitation Services provided as part of Home Health or Hospice Care.

Other Therapy Services

The Plan will provide benefits for Therapy Services for:

- Cardiac rehabilitation
- Pulmonary rehabilitation.
- Chemotherapy
- Dialysis
- Radiation therapy
- Inhalation Therapy
- Post-Cochlear Implant Aural Therapy
- Cognitive Rehabilitation Therapy

**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.

**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.

Donor costs that are related to organ removal are Covered Services for which benefits are payable under the Plan.

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

Live Donor Health Care Services

The Plan provides benefits for Medically Necessary health care services for a live donor when the donor is providing an organ to a Covered Person. Donor medical expenses will be covered under the recipient's benefits as long as transplant-related benefits remain available under the Plan.

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

# PRESCRIPTION DRUGS

Formulary Drugs

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

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

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

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

We update the Antidote Formulary on an ongoing basis in accordance with federal and state law. Drugs may be added or removed, or additional requirements may be added to approve continued usage of a specific Drug. We will notify You of any Formulary changes that affect Your coverage. If a Drug is removed from the Formulary or coverage is reduced, We will continue to cover the Drug until Your renewal date. Any modification to Drug coverage, including removal of a Drug from the Formulary or addition of new utilization management requirements, will occur only at the time of renewal and will be implemented uniformly across all Plans, with written notice provided at least 60 days in advance.

To ensure Your safety and promote the appropriate use of pain medications, especially opioids, the Plan has a Patient Safety and Pain Management Program. This program is designed to help coordinate care for Covered Persons who may be at risk for medication overutilization.

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

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

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

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

To receive coverage for an Antidote Formulary medication, You need to 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. To request coverage for a medication not listed on the Antidote Formulary, You or Your Health Care Provider can submit a Formulary exception request.

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

Prior Authorization

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

Prior Authorization for Covered Persons with Chronic Conditions

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

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

Tiers of Covered Drugs and Your Cost Share

Your Copayment or Cost Share Percentage amount may vary based on whether the covered Prescription Drug, including covered Specialty Drugs, has been classified by Us as a Tier 1, 2, 3, or 4 Drug.

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

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

of insulin and insulin-related equipment will be covered in the same manner as non-emergency refills.

Tiers are based upon clinical information; the cost of the Drug compared to other similar Drugs used to treat the same or similar condition; the availability of over-the-counter alternatives; and certain clinical economic factors. The Plan reserves the right to apply utilization management strategies, including but not limited to Prior Authorization, Step Therapy, and Quantity Limits, to any covered drug (including GLP-1 receptor agonists and Specialty Drugs) to determine coverage and Medical Necessity.

The different tiers are below:

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

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

Specialty Drugs

Specialty Drugs must be dispensed through a Specialty Pharmacy. Please visit Our website at antidotehealth.com/pharma or call Member Services at the toll-free number on Your ID Card to find out if Your medication is considered a Specialty Drug and/or identify the best Specialty Pharmacy option for you.

How to Fill a Prescription

Prescriptions can be filled at a Network retail Pharmacy or through Our mail-order Pharmacy. If You decide to have Your prescription filled at a Network Pharmacy, You can use the Provider directory to find a Pharmacy near you. You can access the Provider directory at antidotehealth.com/find-a-doctor. You can also call Member Services to help You find a Pharmacy. At the Pharmacy, You will need to provide the pharmacist with Your prescription and Your ID Card. We also offer a three-month (90-day) supply of maintenance medications by mail or from Network retail Pharmacies for specific benefit Plans. These Drugs treat long-term conditions or illnesses, such as high blood pressure, asthma, and diabetes. You can find a list of covered medications on antidotehealth.com/pharma.

Mail Order Program

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

Prescription Drug Synchronization

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

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

If you want to use this benefit, please call the number on the back of Your ID Card to request prescription drug synchronization.

Therapeutic Substitution of Drugs Program

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

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

Step Therapy

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

If Your Provider decides that a step therapy medication is needed, Your Provider may request an exemption. We will review and respond to Your Provider's request for an exemption within twenty-four (24) hours for urgent requests, and within seventy-two (72) hours for all other requests. If We do not deny the request within the applicable timeframe, the exemption request is considered granted. If the exemption is granted, You will be able to obtain the requested medication without needing to proceed through the step therapy protocol.

Opioid Analgesics Prescribed for Chronic Pain

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

- Opioid analgesics prescribed to a Covered Person who is a Hospice patient in a Hospice Care program;
- Opioid analgesics prescribed to a Covered Person who has been diagnosed with

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

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

Orally Administered Chemotherapy

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

Prescription Eye Drops

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

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

Your Right to Request a Formulary Exception

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

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

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

*Urgent Formulary Exception Requests*

If Your exception request is exigent (urgent) and requires immediate action such that a

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

*Approval/Denial of Formulary Exception Requests*

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

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

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

*Standard External Review*

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

*Expedited External Review*

If You are not satisfied with Our determination of Your Formulary exception request and it involves an urgent situation, You, Your Authorized Representative or Your Provider may request an expedited external review by calling the toll-free number on Your ID Card or by sending a written request to the address set out in the determination letter. The IRO will notify You and Your Provider of Our determination within twenty-four (24) hours.

*Negative Formulary Changes*

Negative Formulary changes include, but are not limited to:

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

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

- Branded medications that have A-rated equivalent generics or an equivalent chemical entity available at an equal or lower tier.

- Products that have been recalled by the FDA.

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

Off-Label Use

Except as otherwise noted in the Plan, Drugs must be approved by the Food and Drug Administration (FDA) for treatment of the condition for which it is prescribed to be covered. We cover off-label uses when the Drug is recognized for treatment of the condition for which it is prescribed by:

- the American Hospital Formulary Service Drug Information; a publication of the American Society of Health-System Pharmacists.
- the United States Pharmacopoeia Dispensing Information, Volume 1, “Drug Information for the Health Care Professional”; or
- two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective for treatment of the condition unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

## EMERGENCY, AFTER-HOURS AND URGENT CARE

### Emergency Services

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

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

### Care After Your Condition is Stabilized

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

- **The Out-of-Network Provider's Responsibility**: Texas law requires the Out-of-Network Provider or facility to contact Us for authorization to provide any further care

after You are stable. They must make this notification no later than the **next business day** after you are admitted.

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

We do not provide coverage for out-of-area services for anything other than Emergency Services as outlined above and Urgent Care services are subject to the conditions specified in the Urgent Care section of the Policy. Be sure to call Us and report Your emergency within the timeframe specified above.

**After-Hours Care**

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

**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 an Out-of-Network Urgent Care Center while You are temporarily outside the Service Area. Benefits provided under this section are payable at the Network level and are limited to the Maximum Allowable Amount. Your payment is subject to any Cost Share Percentage, 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. Certain Urgent Care services are available by contacting Antidote at 888-623-3195 or antidotehealth.com/member.

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

## OUT-OF-AREA SERVICES

Coverage outside the Service Area is limited to Emergency Services, post-stabilization services as required by law, and authorized Urgent Care services while You are temporarily outside the Service Area.

- Emergency Services are covered outside the Service Area and are subject only to in-network Cost-Sharing, as required by law.
- Post-stabilization services received at an Out-of-Network facility are covered as required by law until the Covered Person can be safely transferred to a Network Provider.
- Urgent Care services received while You are temporarily outside the Service Area may be covered at the in-network level, subject to Plan requirements.

## BALANCE BILLING

**Balance Billing Protections (No Surprises Act)**

The No Surprises Act (NSA) protects You from receiving surprise medical bills under the following circumstances:

- Emergency services, including post-stabilization services.
- Non-emergency care from Out-of-Network Providers, such as anesthesiologists and pathologists at 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 need to give written consent to be transferred.

- Non-Emergency Services provided at In-Network facilities, such as Out-of-Network anesthesiologists, radiologists, and other ancillary care Providers whom You did not select but who provide services for the In-Network Facility. These Providers bill for services separately from the Facility and may not contract with the Antidote Health Plan.

In these cases, you will only be responsible for your in-network cost-sharing amounts.

If You receive a surprise medical bill and have questions, please call Us at 888-623-3195

## COST-SHARING AND PAYMENT OBLIGATIONS

You are responsible for certain costs when You receive Covered Services under the Plan. These may include:

**Allowed Amount**

The Allowed Amount is the maximum amount We will pay for a Covered Service. 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 the Policy, You will also be responsible for any applicable Deductibles, Cost Share Percentage and Copayment amounts.

**Deductible**

You need to pay the Deductible for Covered Services during each calendar year before the Plan begins to pay for certain benefits. The Deductible applies to each person covered under the Plan.

**Copayments**

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

**Cost Share Percentage**

Some of the care and treatment You receive under the Plan will require that a Cost Share Percentage be paid at the time You receive the services. After you have satisfied the Deductible described above, You are required to pay a Cost Share Percentage of the Allowed Amount for Covered Services. The Plan will pay the remaining percentage of the Allowed Amount as shown in the Schedule of Benefits.

**Maximum Out-of-Pocket**

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

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

- Cost-Sharing for Out-of-Network services, except for Emergency Services and

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

When the maximum Out-of-Pocket is reached in a Plan year, Covered Service expenses are payable at 100%.

**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 Cost Share Percentage.

**Payment of Premiums**

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

**Grace Period**

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

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

## [schedule of benefits]

# 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 the responsibility of the Provider to pay.
- Any services not identified and included as Covered Service expenses under the contract. You will be fully responsible for payment for any services that are not Covered Service expenses.

Even if not specifically excluded by this contract, no benefit will be paid for a service or supply unless it is administered or ordered by a Physician or other licensed Health Care Provider acting within the scope of their license and Medically Necessary to the diagnosis or treatment of an Injury or illness or covered under the Preventive Care provision.

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

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

- For eye refractive surgery when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
- While confined primarily to receive rehabilitation, Custodial Care, educational care, or nursing services (unless expressly provided for in the contract).
- For vocational or recreational therapy, vocational rehabilitation, Outpatient speech therapy, or occupational therapy, except as expressly provided for in the contract.
- For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine.
- For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in the contract.
- For Hearing Aid or assistive listening device batteries, including rechargeable batteries, any size and Hearing Aid or assistive listening device cords, or other routine maintenance supplies except as expressly provided in the contract. The Plan strictly excludes OTC hearing devices, BAHAs, and devices not prescribed and dispensed following a clinical hearing evaluation.
- Cochlear implant benefit does not cover the purchase of batteries, cords, alternative cosmetic faceplates, or routine external maintenance. Standard maintenance or upgrades requested solely for technological advancement (when the current processor is still functional) are not Covered Services.
- For Experimental or Investigational treatment(s) or unproven services. The fact that an Experimental or Investigational treatment or unproven service is the only available treatment for a particular condition will not result in benefits if the procedure is an Experimental or Investigational treatment or unproven service for the treatment of that condition. These services may be related to medical, surgical, diagnostic, psychiatric, Substance Use or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan to be:
    - Not approved by the FDA to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
    - The subject of review or approval by an Institutional Review Board for the proposed use;
    - The subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight (except as set forth in the Cancer Clinical Trials provision of the Plan under Covered Services and Supplies; or
    - Not demonstrated, through existing peer reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
- For treatment received outside the United States, except for Emergency Services while traveling for up to a maximum of ninety (90) consecutive days.
- Transportation, lodging and travel related expenses.

- Transplant or post-transplant care if the transplant was performed in China, or another country known to have participated in forced organ harvesting.
- A transplant for which the organ to be transplanted was procured by sale or donation.
- As a result of an Injury, disease, defect, or ailment arising out of and in the course of employment for wage or profit, if the Covered Person is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If workers' compensation insurance is not available to You, then this Exclusion does not apply. This Exclusion applies if You receive the benefits in whole or in part. This Exclusion also applies whether You claim the benefits or compensation. It also applies whether You recover from any third party. If You enter 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. If 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. Health care services, including related supplies and medication, to You serving as a surrogate/gestational carrier are excluded.
- 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.
- 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.

Prescription Drug Exclusions and Limitations

In addition to the Exclusions listed above, the following Exclusions apply specifically to the Prescription Drug benefits:

- For Prescription Drugs for the treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the Formulary.
- For weight loss Prescription Drugs unless otherwise listed on the Formulary.
- For immunization agents, blood, or blood plasma, except when used for preventive care and listed on the Formulary.
- For medication that is to be taken by the Covered Person, in whole or in part, at the place where it is dispensed.
- For medication received while the Covered Person is a patient at an institution that has a Facility for dispensing pharmaceuticals.
- For a refill dispensed more than twelve (12) months from the date of a Physician's order.
- For more than the predetermined managed Drug limitations assigned to certain Drugs or classification of Drugs.
- For a Prescription Order that is available in over-the-counter form or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are on the Formulary.
- For Drugs labeled "Caution - limited by federal law to investigational use" or for Investigational or Experimental Drugs.
- For any Drug that We identify as therapeutic duplication through the Drug Utilization Review program. Therapeutic duplication is the practice of prescribing multiple medications for the same indication or purpose without a clear distinction of when one agent should be administered over another.
- For more than a 30-day supply when dispensed in any one prescription or refill, or for maintenance Drugs, up to 90-day supply when dispensed by mail order or a Pharmacy that participates in extended day supply network.
    - Specialty Drugs and other select Drug categories are limited to 30-day supply when dispensed by retail or mail order. Please note that only the 90-day supply is subject to the discounted Cost-Sharing. Mail orders supplies of fewer than 90 days are subject to the standard Cost-Sharing amount.
- For Prescription Drugs for any Covered Person who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription Drug coverage may not be reinstated later.
- Foreign prescription medications, except those associated with an Emergency Medical Condition while You are travelling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this document, if obtained in the United States.
- For medications used for cosmetic purposes, excluding Tretinoin.
- For infertility Drugs unless otherwise listed on the Formulary.
- For any controlled substance that exceeds state established maximum morphine

equivalents in a particular 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 to monitor prescription 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.

Please see the Policy for a complete list of exclusions.

There may be limits applied to certain Covered Services in the form of an annual maximum on the number of visits, days or events the Policy will cover for a specific type of service. The expenses You incur which exceed specific maximums described in the Policy will be Your responsibility. Any special limits applicable to benefits in the Policy are described in the Schedule of Benefits.

## PRIOR AUTHORIZATION

Some services and items require Prior Authorization. Prior Authorization is the process used by Us to determine whether health care services listed on Our Prior Authorization Grid meet evidence-based criteria for Medical Necessity and coverage requirements and are Covered Services under Your Plan prior to the health care service being rendered. It is the responsibility of Your Network Provider to obtain Prior Authorization from Us prior to providing a service or supply to a Covered Person. Please check with Your Network Provider to ensure that Your Network Provider has obtained Prior Authorization before You receive any health care services listed on the Prior Authorization Grid. The Prior Authorization Grid is available by calling Member Services at 888-623-3195 Monday through Friday 8:00 a.m. to 8:00 p.m. or by viewing it in the Member section on Our website at antidotehealth.com/plandocs. Except for Emergency

Services, services provided by an Out-of-Network Provider are considered non-Covered Services.

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

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

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

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

- At least five (5) days prior to an elective or scheduled admission as an Inpatient in a Hospital, extended care or rehabilitation Facility, or Hospice Facility or as soon as reasonably possible.
- At least thirty (30) days prior to the initial evaluation for organ transplant services or as soon as reasonably possible.
- At least thirty (30) days prior to receiving clinical trial services or as soon as reasonably possible.
- Within twenty-four (24) hours of any Inpatient admission, including emergent Inpatient admissions.
- At least five (5) days prior to the start of Home Health Care except for Covered Persons needing Home Health Care after Hospital discharge.

Emergency services do not require prior authorization. Except for Emergency Services, services provided by an Out-of-Network Provider are considered non-Covered Services.

**Reconsideration of Adverse Benefit Determination**

For Adverse Benefit Determinations related to concurrent service requests or pre-service requests, Your Provider or Facility rendering the Covered Service may request, in writing on Your behalf, a reconsideration of the Adverse Benefit Determination by conducting a peer-to-peer review. The Provider or Facility may not request reconsideration without Your prior written consent.

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

consent in order to conduct this peer-to-peer review with the Plan's reviewer or the Plan's designee.

Note: Additional information is available in the section entitled "Utilization Review Decisions, Timeframes and Procedures."

## UTILIZATION REVIEW

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

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

# CONTINUITY OF CARE

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

This protection applies in two situations:

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

**Continuity of Care Eligibility**

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

- An Acute or Serious and Complex Condition: A condition serious enough that a change of providers could lead to a relapse or complication.
    - Duration: The Plan will continue to cover treatment up to ninety (90) days from the date You are notified of the provider's termination, or until the course of treatment is complete, whichever is shorter.
- A Chronic Condition: A life-threatening, degenerative, or disabling disease or condition.
    - Duration: The Plan will continue to cover treatment up to 90 days from the date You are notified of the provider's termination, or until the course of treatment is complete, whichever is shorter.
- A Pregnancy: If You are undergoing a course of obstetrical treatment, including if You are past the 24$^{th}$ week of pregnancy.
    - Duration: The Plan will continue to cover treatment by the terminated provider through the completion of your postpartum period.
- A Terminal Illness: An advanced, incurable, or irreversible medical condition that has a high probability of causing death within six (6) months or less. Examples of terminal illnesses include, but are not limited to, metastatic (Stage IV) cancer, end-stage renal (kidney) disease, advanced congestive heart failure (Class IV), or advanced Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's disease).
    - Duration: The Plan will continue to cover treatment by the terminated provider for a period of up to nine (9) months from the effective date of the termination.

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

**Continuity of Care Protections**

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

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

**How to Request Continuity of Care**

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

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

## APPEALS AND COMPLAINT PROCEDURES

You have the right to file a complaint or appeal a decision. You may also request an independent review by an Independent Review Organization (IRO).

**Call Member Services**

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

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

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

**Grievance Procedure**

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

**Appeals**

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

Internal Appeal Process

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

For internal appeals not requiring an expedited timeline, the appeal will be considered within thirty (30) calendar days after We receive it. We will provide Adverse Determination notices in writing that include the principal reason for the denial, the clinical basis for the decision, a description of or the source of the screening criteria that were used, and specialty of the physician or other Health Care Provider who issued the determination. The notice will also describe Your appeal rights and Your right to request an Independent Review Organization review, if applicable.

Expedited Internal Appeal - Standard

You can file an expedited appeal when a requested service involves a situation that would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function or in the opinion of a physician with knowledge of Your condition, would subject You to severe paid than cannot be adequately managed without the requested care. This type of appeal must be documented with clinical information.

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

We will decide about the request no later than one (1) business day after receiving all information needed to make a decision. We will notify You and Your Authorized Representative of the result. In accordance with state law, We will include all required information related to Your right to request immediate IRO review when applicable.

Expedited Internal Appeal – Concurrent Review

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

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

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

External Appeal

If You, or Your Authorized Representative, are not satisfied with the final outcome of the Internal Appeal, an external appeal by an Independent Review Organization (IRO) administered through the Texas Department of Insurance (TDI) may be requested. You, or Your Authorized Representative, can request an external review by an Independent Review Organization (IRO) when the appeal is of Adverse Benefit Determinations based on Medical Necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. We will send instructions and the approved TDI IRO request form with the denial notice. For non-urgent cases, complete, sign, and return the form to Us to begin the IRO process. We will forward it to the Texas Department of Insurance within one working day as required.

Filing an external review will not affect Your healthcare services. We want to know Your concerns so We can improve Our services. An external review decision is binding on Us. An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law. We will pay for the costs of the external review performed by the independent reviewer.

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

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

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

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

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

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

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

Urgent Request for an External Appeal

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

For denials involving the interruption of an on-going course of treatment with a Prescription Drugs or intravenous infusions for which You are receiving benefits under a current course of treatment, the IRO will provide a determination by phone and follow up with written or electronic notice no later than the fifth day after receiving either the necessary information or the request.

Non-Urgent Request for an External Appeal

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

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

External Reviews for Experimental or Investigational Services

An external review for an Experimental or Investigational Service is similar to a standard or expedited external review. The most significant difference is that these are external reviews of Adverse Benefit Determinations when benefits have been denied for a health

care service that We have determined to be an Experimental or Investigational Service unless the requested health care service is specifically listed as an Exclusion in this Policy. You or Your Authorized Representative may request an external review for Experimental or Investigational Services only if Your treating Physician certifies that one of the following situations applies:

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

## PROVIDER DIRECTORY & NETWORK INFORMATION

**Finding a Provider**

A listing of Network Providers is available online at antidotehealth.com/find-a-doctor.

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

In addition, We have Plan Providers, Hospitals, and other medical practitioners who have agreed to provide You healthcare services. You can find Our Network Providers by visiting Our website and using the "Find a Doctor" function. There You will have the ability to narrow Your search by Provider specialty, zip code, gender, languages spoken and whether they are currently accepting new patients.

Your search will produce a list of Providers based on Your search criteria and will give You other information such as name, address, phone number, office hours, qualifications, specialty, and board certifications.

At any time, You can request a printed copy of the Provider directory at no charge by calling Member Services at the toll-free number on Your ID Card. Call the Provider's office if You want to make an appointment. If You need help, call Member Services at the toll-free number on Your ID Card. We will help You make the appointment.

**Network Providers**

The Plan only covers Network benefits. To receive Network benefits, You need to receive care exclusively from Providers in the Network. Services must be performed or supplies furnished by a Network Provider for benefits to be payable. There are no benefits provided when using an Out-of-Network Provider and You will be responsible for paying the cost of all care that is provided by Out-of-Network Providers unless We have Prior Authorized that care or the Out-of-Network Provider is administering Emergency Services.

Network Providers will seek compensation for Covered Services solely from Antidote, except for Copayments, Cost Share Percentage and/or Deductibles. To reduce Your Out-of-Pocket costs, be sure to confirm that the Provider You wish to see is a Network Provider. For example, if You are treated for a non-Emergency Service in a Hospital, it is especially important to check ALL Your Providers' Network statuses. While Your treating Provider may be participating in the Antidote Network, other Providers involved, such as anesthesiologists, pathologists, or radiologists, may not be part of Your Network of Providers.

We may pay for certain Medically Necessary Out-of-Network services if Antidote determines that You received such services on an involuntary basis because of receiving Covered Services from a Network Provider, did not elect to receive Services from an Out-of-Network Provider, and a Network Provider was not available to render such Medically Necessary Services to You. You will not be billed more than Your In-Network Cost-Sharing amount for Covered Services provided under these circumstances, in accordance with applicable law. Any applicable Copayment, Cost Share Percentage and Deductible would apply to Your maximum Out-of-Pocket.

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

**Out-of-Network Providers**

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

For emergency care, or for care you receive from an Out-of-Network Physician at a Network Hospital, you are only responsible for your In-Network Cost-Sharing. These Providers cannot Balance Bill you for any additional amount unless You knowingly choose to waive this protection in writing beforehand.

A Facility-based Provider or other health care practitioner may not be included in the Plan's network. Unless You elect to receive Out-of-Network care and sign a waiver of Balance Billing protections, an Out-of-Network Facility-based Provider or other health care practitioner may not Balance Bill You for amounts not paid by the Plan for Covered Services provided at a Network Facility.

When You visit an Out-of-Network Provider for Prior Authorized services not available from Network Providers, or if You cannot reach a Network Provider for Emergency Services, We will pay the claim at the In-Network benefit Cost-Sharing level and when issuing payment, provide You with an explanation of benefits.

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

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

NOTE: If You receive a bill for covered services from any physician or provider, including a facility-based physician or other health care practitioner, please contact Us at 888-623-3195.

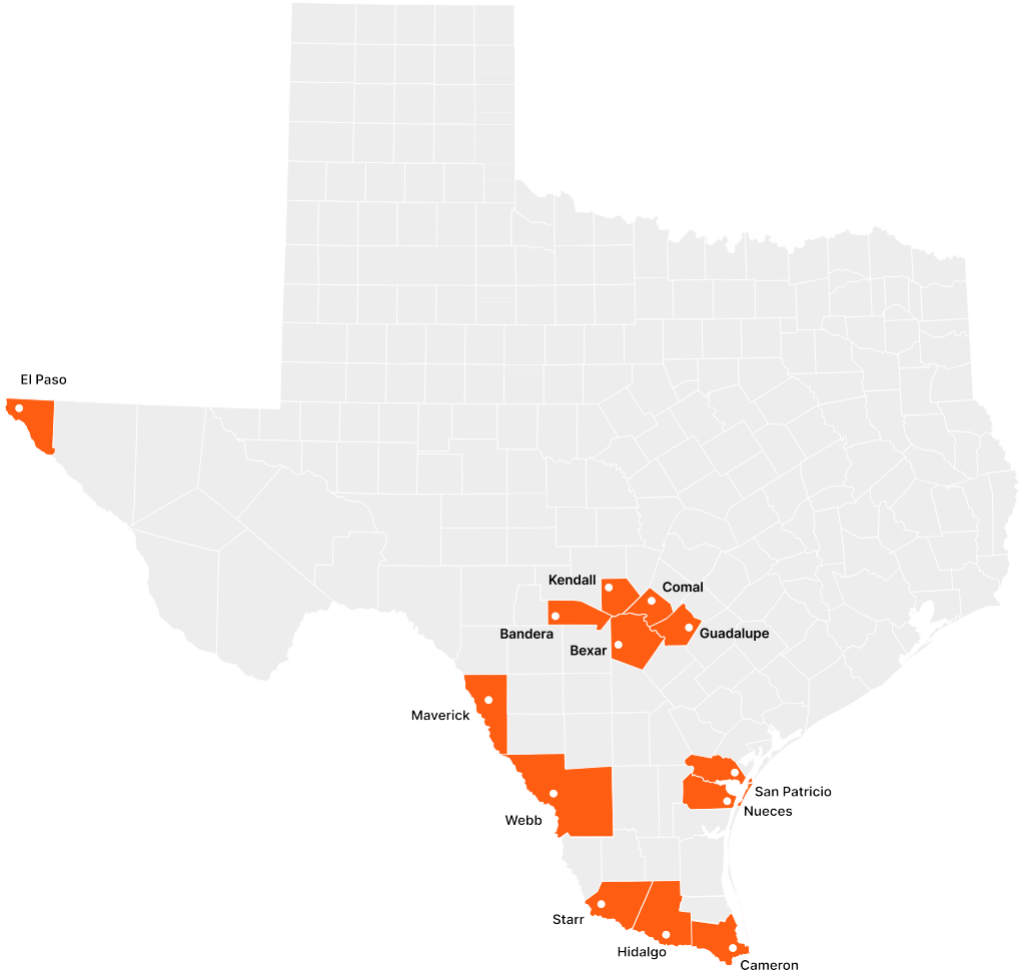
## SERVICE AREA

Emergency services are available at any Out-of-Network Hospital, within or outside of the Service Area. Benefits are also available for Urgent Care services received at an Out-of-Network Urgent Care centers while You are temporarily outside the Service Area.

Except as described above for Emergency Services and Urgent Care received while temporarily outside the Service Area, coverage for non-Emergency Services is available only within the Plan's designated Texas Service Area, which includes multiple counties across the state.

A complete list of covered counties is available on the Service Area map or by contacting Member Services.

# Texas
## PY 2027




### Texas Partners at Health System Level

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

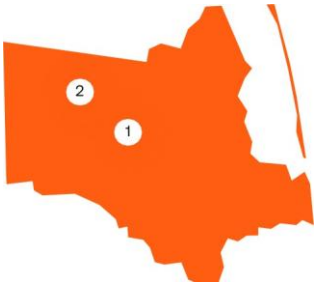
### Antidote Health Mapping of Markets to Counties & Rating Areas

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

© 2026 Antidote Health. All rights reserved.

ANTIDOTE

# Facilities by County




## Brownsville:
Cameron

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

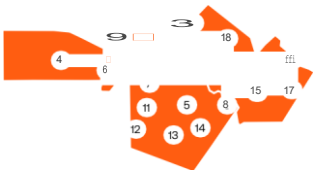



## El Paso:
El Paso

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

© **2026 Antidote Health.** All rights reserved.

ANTIDO+E

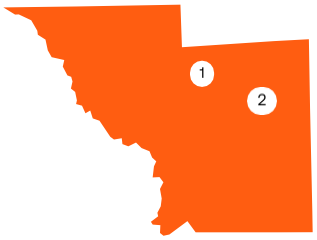


# San Antonio:
## Bandera, Bexar, Comal, Guadalupe, Kendall, Maverick

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

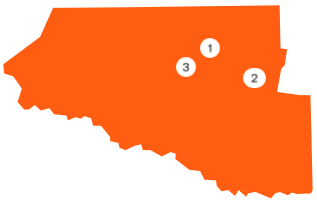
© **2026 Antidote Health.** All rights reserved.

ANTIDO+E



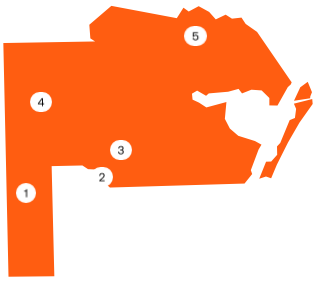

## Laredo:
Webb

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




## McAllen:
Hidalgo, Starr

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




## Corpus Christi:
Nueces, San Patricio

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

© 2026 Antidote Health. All rights reserved.

ANTIDOTE