This is Your

EXCLUSIVE PROVIDER ORGANIZATION POLICY

Issued by

Oscar Insurance Company of Texas

This is Your individual direct payment Policy for exclusive provider organization coverage issued by Oscar Insurance Company of Texas. This Policy, together with the Schedule of Benefits, applications and any amendment or rider amending the terms of this Policy, constitute the entire agreement between You and Us.

You have the right to return this Policy. Examine it carefully. If You are not satisfied, You may return this Policy to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Policy. We will refund any Premium paid including any Policy fees or other charges.

Notice: If You or Your Family Members are covered by more than one health care plan, You may not be able to collect benefits from both plans. Each plan may require You to follow its rules or use specific doctors and hospitals, and it may be impossibel for You to comply with both plans at the same time. Read all of the rules carefully, including the Coordination of Benefits section, and compare them with the rules of any other plan that covers You or Your Family.

READ THIS ENTIRE POLICY CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS POLICY. IF YOU HAVE ANY QUESTIONS ABOUT THIS POLICY OR ANY MATTER RELATED TO YOUR MEMBERSHIP WITH THE PLAN, PLEASE WRITE OR CALL US AT:

Oscar Insurance
PO Box 52146
Phoenix, AZ 85072-2146
855-OSCAR-55

This Policy is governed by the laws of the State of Tennessee.

TABLE OF CONTENTS

SECTION 1: DEFINITIONS

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

Advanced Premium Tax Credit: Financial help that lowers Your taxes to help You and Your family pay for private health insurance. You can get this help if You get health insurance through the Marketplace and Your income is below a certain level. Advance payments of the tax credit can be used right away to lower Your monthly Premium.

Adverse Benefit Determination: Any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service. Adverse Benefit Determinations include:

- A determination by Us or Our designee utilization review organization that, based upon the information provided, a request for a benefit under the Plan does not meet the Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
- The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Us of a Covered person's eligibility to participate in the Plan; or
- Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment for, in whole or in part, a benefit.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Policy for a description of how the Allowed Amount is calculated.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Authorized Service(s): A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the

Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible. For more information, see the Claims Payment section.

Balance Billing: When a Non-Network Provider bills You for the difference between the Non-Network Provider's charge and the Allowed Amount. A Network Provider may not Balance Bill You for Covered Services.

Behavioral Health Services: Services or supplies to treat a mental or emotional condition or substance use disorder.

Benefit Period: The length of time that We will pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If Your coverage ends before this length of time, then the Benefit Period also ends.

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

Billed Charges: The amount that a Provider charges for services rendered. Billed Charges may be different from the amount that We determine to be the Allowed Amount for services.

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

Care Management or Case Management: Programs that promotes cost-effective coordination of care for Members with low-risk health conditions and/or complicated medical needs.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Policy.

Coinsurance: A specific percentage of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which You must pay. Coinsurance normally applies after the Deductible that You are required to pay. See

the Schedule of Benefits for any exceptions.

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

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

Cost-Sharing Reductions (CSRs): Discounts that lower Cost-Sharing for certain services covered by individual HMO or health insurance purchased through the Exchange. You may get a discount if Your income is below a certain level and You choose a silver level plan. If You are a member of a federally recognized tribe, You can qualify for Cost-Sharing Reductions on certain services covered by individual HMO or health insurance purchased through the Exchange at any metal level and You may qualify for additional Cost-Sharing Reductions depending upon Your income.

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

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

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

Dependent: The Subscriber's spouse or children, who are covered under the Policy, as described in the Who is Covered section.

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

Dispute or Grievance: Any matters that cause You to be dissatisfied with any aspect of Your relationship with Us; any Adverse Benefit Determination concerning a claim; or any other claim, controversy, or potential cause of action You may have against Us.

Domiciliary Care: Care provided in a residential institution, treatment center, halfway house, or school because Your own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Durable Medical Equipment (DME): Equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

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

Emergency: A sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses average knowledge of health and medicine could reasonably expect to result in:

- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part; or
- Placing the prudent layperson's health in serious jeopardy.

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

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;

- Serious dysfunction of any bodily organ or part.

Emergency Care Services: Those services and supplies that are Medically Neessary in the treatment of an Emergeny and delivered in a hospital Emergency department.

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

Experimental/Investigative: Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be unproven. For how this is determined, see the Exclusions section.

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; Hospice; Home Health Agency or home care services agency certified or licensed under state law; a comprehensive care center for eating disorders pursuant to state law.

Formulary: The list of covered pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness.

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

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

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist;

audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Policy.

Home Health Agency: An organization currently certified or licensed by the State of Tennessee or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to state law or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, Diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas or infirmaries at schools or camps.

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

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

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

SECTION 1: DEFINITIONS

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

Medically Necessary / Medical Necessity: See the How Your Coverage Works section of this Policy for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent who has satisfied the eligibility conditions, applied for coverage been approved by Us and for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to the terms of this Policy, "Member" also means the Member's designee.

Network Provider: A Provider who has a contract with Us to provide services to You. A list of Network Providers and their locations is available on Our website at www.hioscar.com or upon Your request to Us. The list will be revised from time to time by Us.

Non-Network Provider: A Provider who doesn't have a contract with Us to provide services to You. The services of Non-Network Providers are covered only for Emergency Services, Urgent Care or when authorized by Us.

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

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

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

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan (or We, Us, Our): Oscar Insurance Company of Texas (Oscar), which provides benefits to Members for the Covered Services described in this Policy.

Policy: This Policy issued by Oscar Insurance Company of Texas, including the Schedule of Benefits and any attached riders. The Policy provides a summary of the terms of Your benefits.

Preauthorization or Prior Authorization: The process applied to certain services, supplies, treatment, and Drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prescription Drugs and their criteria for coverage are defined by the P&T Committee.

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

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

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

Primary Care Physician (PCP): A Network Provider who typically is an internal medicine, family practice, general practice, obstetrics/gynecology, geriatrics or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional, or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, DME, medical supplies, or any other equipment or supplies that are covered under this Policy that is licensed, registered, certified or accredited as required by state law.

Providers include, but are not limited to, the following persons and facilities listed

below. If You have a question about a Provider not shown below, please call the number on the back of Your ID card.

- **Alcoholism Treatment Facility** - A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.
- **Alternative Care Facility** – A non-Hospital health care facility, or an attached facility designated as free standing by a Hospital that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI)
    2. Surgery
    3. Therapy Services or rehabilitation.
- **Ambulatory Surgical Facility** - A facility, with an organized staff of Physicians, that:
    1. Is licensed as such, where required;
    2. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    3. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    4. Does not provide Inpatient accommodations; and
    5. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.
- **Clinical Nurse Specialists whose nursing specialty is Mental Health**
- **Day Hospital** - A facility that provides day rehabilitation services on an Outpatient basis.
- **Dialysis Facility** - A facility which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at Your home. It is not a Hospital.
- **Drug Abuse Treatment Facility -** A facility which provides detoxification and/or rehabilitation treatment for drug abuse.
- **Home Health Care Agency - A facility, licensed in the state in which it is located, which:**
    1. Provides skilled nursing and other services on a visiting basis in the Member's home; and
    2. Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- **Home Infusion Facility** - A facility which provides a combination of:
    1. Skilled nursing services
    2. Prescription Drugs
    3. Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.
- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:
    1. Provides room and board and nursing care for its patients;
    2. Has a staff with one or more Physicians available at all times;
    3. Provides 24 hour nursing service;
    4. Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
    5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Treatment of alcohol abuse
8. Treatment of drug abuse

- **Independent Social Workers**
- **Outpatient Psychiatric Facility** - A facility which mainly provides Diagnostic and therapeutic services for the treatment of Behavioral Health Conditions on an Outpatient basis.
- **Pharmacy -** An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.
- **Physician -** A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), Chiropractor (spinal column and other body

structures), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or optometrist (eye and sight specialist).

- **Professional Clinical Counselors**
- **Professional Counselors**
- **Psychiatric Hospital** - A facility that, for compensation of its patients, is primarily engaged in providing Diagnostic and therapeutic services for the Inpatient treatment of Behavioral Health Conditions. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Psychologist** - A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.
- **Rehabilitation Hospital** - A facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Retail Health Clinic** - A facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.
- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:
    1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
    2. provides care supervised by a Physician;
    3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
    4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
    5. is not a rest, educational, or custodial Provider or similar place.
- **Social Worker** - A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.
- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center** - A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

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

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

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

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

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

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

Stabilize: The provision of such medical treatment as may be necessary to assure,

within reasonable medical probability, that no material deterioration of an individual's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

Subcontractor: An organization or entity that has specialized expertise in certain areas to whom we may subcontract particular services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber: The person to whom this Policy is issued.

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

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a Physician’s office or Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

You, Your: The Member.

SECTION 2: HOW YOUR COVERAGE WORKS

A. Your Coverage Under this Policy.

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

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Policy only when the Covered Service is:

- Medically Necessary or otherwise specifically included as a Covered Service under this Policy;
- Provided by a Network Provider;
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Policy is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Policy, or by any amendment or rider thereto; and
- Authorized in advance by Us if such Preauthorization is required in this Policy.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to You. The incurred date (for determining application of Deductible and other Cost-Sharing) for an Inpatient admission is the date of admission except as otherwise specified in benefits after termination. Covered Services do not include any services or supplies that are not documented in Provider records.

When You are outside Our Service Area, coverage is limited to Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition and Urgent Care.

C. Network Providers.

This Policy only covers Network benefits. To receive Network benefits, You must receive care exclusively from Network Providers in Our network. Except for Emergency or Urgent Care Services described in the Emergency and Urgent Care Services section of this Policy, You will be responsible for paying the cost of all care that is provided by Non-Network Providers.

In the event that We becomes insolvent, You may be financially responsible for health care services rendered by a Non Network Provider or Facility, even if the We authorized the service. Except for Copayments and Deductibles, Providers must seek compensation for Covered Services solely from Us.

To find out if a Provider is a Network Provider:

- Check Your Provider directory, available at Your request;
- Call 855-OSCAR-55; or
- Visit Our website at www.hioscar.com.

D. The Role of the Primary Care Physicians.

This Policy does not have a gatekeeper, usually known as a PCP. You do not need a Referral from a PCP before receiving Specialist care.

For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in Your Schedule of Benefits Policy when the services provided are related to specialty care.

We generally allow the designation of a PCP. You have the right to designate any PCP who participates in Our Network and who is available to accept You or Your family members. For information on how to select a PCP, and for a list of PCPs, contact Us at the phone number on Your ID Card or visit Our website at www.hioscar.com. For children, You may designate a pediatrician as the PCP.

E. Access to OB/GYN Care.

You do not need Preauthorization from Us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a Health Care Professional in Our Network who specializes in obstetrics or gynecology. The Health Care Professional, however, may be required to comply with certain procedures, including obtaining Preauthorization for certain services or following a pre-approved treatment plan. For a list of Network Health Care Professionals who specialize in obstetrics or gynecology, contact the phone number on Your ID Card or visit Our website at www.hioscar.com.

F. Services Subject to Preauthorization.

All Network Preauthorization requests are the responsibility of Your Network Provider. You will not be penalized for a Network Provider's failure to obtain a

required Preauthorization. However, if services are not covered under the Policy You will be responsible for the full cost of the services.

G. Prior Authorization / Notification Procedure.

If You seek coverage for services that require Preauthorization or notification, Your Network Provider must call Us at the number on Your ID card.

Your Network Provider must contact Us to request Preauthorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when Your Provider recommends Inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.
- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.
- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if Your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.
- Before air ambulance services are rendered for a non-Emergency Condition.

You must contact Us to provide notification as follows:

- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.
- If You are hospitalized in cases of an Emergency Condition, You must call Us within 48 hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

H. Medical Management.

The benefits available to You under this Policy are subject to pre-service, concurrent and retrospective reviews to determine when services should be Covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical

care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

I. Medical Necessity.

We Cover benefits described in this Policy as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

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

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not Experimental/Investigative nor subject to an Exclusion under this Policy;
- They are not more costly than an alternative service or sequence of services,

that is at least as likely to produce equivalent therapeutic or diagnostic results;

- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, We will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an Outpatient basis or an infusion or injection of a specialty drug provided in the Outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

See the Utilization Review and Complaints, Appeals and External Review sections of this Policy for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

J. Case Management.

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

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

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care through Our case management program that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Policy. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us.

Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or

approving alternate care. In such case, We will notify You or Your representative in writing.

K. Value Add and Incentive Programs:

We may offer health or fitness related programs and products to our Members. We may also offer value-added services that include discounts on Pharmacy products (over the counter drugs, consultations, and biometrics). The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under Your Agreement and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

L. Important Telephone Numbers and Addresses.

- CLAIMS
  Oscar Insurance
  PO Box 52146
  Phoenix, AZ 85072-2146
  (Submit claim forms to this address.)

  Payer ID: OSCAR
  (Submit electronic claims to this ID.)

  claims-submissions@hioscar.com
  (Submit other claims to this e-mail address.)

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  Oscar Insurance
  PO Box 52146
  Phoenix, AZ 85072-2146
  855-OSCAR-55

- MEDICAL EMERGENCIES AND URGENT CARE

855-OSCAR-55

- MEMBER SERVICES
  855-OSCAR-55

- PREAUTHORIZATION
  855-OSCAR-55

- OUR WEBSITE
  www.hioscar.com

SECTION 3: ACCESS TO CARE

A. Network Providers

Services must be performed or supplies furnished by a Network Provider in order for benefits to be payable. There are no Benefits provided when using a Non-Network Provider and You may be responsible for the total amount billed by a Non-Network Provider. The only exception is for Emergency or Urgent Care Services, or an Authorization to a Non-Network Provider.

To maximize Your benefits, be sure to confirm that the Provider (e.g. a Physician or Hospital) You wish to see is a Network Hospital or 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 Oscar network, other Providers involved, such as anesthesiologists, pathologists, or radiologists, may not be part of Your Network of Providers. However, these providers will be paid as Network Providers if a Network Facility or Network Provider is used.

B. Authorization to a Non-Network Provider.

If We determine that We do not have a Network Provider that has the appropriate training and experience to treat Your condition, We will approve an authorization to an appropriate Non-Network Provider. Your Network Provider or You must request prior approval of the authorization to a specific Non-Network Provider. Approvals of authorizations to Non-Network Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Network Provider You requested. If We approve the authorization, all services performed by the Non-Network Provider are subject to a treatment plan approved by Us in consultation with Your PCP, the Non-Network Provider and You. Covered Services rendered by the Non-Network Provider will be paid as if they were provided by a Network Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event an authorization is not approved, any services rendered by a Non-Network Provider will not be Covered.

SECTION 4: COST-SHARING EXPENSES AND ALLOWABLE AMOUNT

A. Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits for Covered Services during each Benefit Period before We provide coverage. If You have other than individual coverage, there is an individual Deductible which applies to each person covered under this Policy. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Benefit Period. However, after Deductible payments for persons covered under this Policy collectively total the family Deductible amount in the Schedule of Benefits in a Benefit Period, no further Deductible will be required for any person covered under this Policy for that Benefit Period.

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

B. Copayments.

Except where stated otherwise, after You have satisfied the Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

C. Coinsurance.

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

D. Out-of-Pocket Limit.

When You have met Your Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Benefit Period in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Benefit Period. If You have other than individual coverage, once a person within a family meets the individual Out-of-Pocket Limit in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for the rest of that Benefit Period for that person. If other than individual coverage applies, when persons in the same family covered under this Policy have collectively met the family Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Benefit Period in the Schedule of Benefits, We will provide

coverage for 100% of the Allowed Amount for the rest of that Benefit Period for the entire family.

E. Allowed Amount.

The Allowed Amount means the maximum amount We will pay for the services or supplies Covered under this Policy, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Network Providers will be the amount We have negotiated with the Network Provider or the Network Provider's charge.

See the Emergency and Urgent Care Services section of this Policy for the Allowed Amount for an Emergency Condition.

SECTION 5: WHO IS COVERED

A. Who is Covered Under this Policy.

You, the Subscriber to whom this Policy is issued, are covered under this Policy. You must live or reside in Our Service Area to be covered under this Policy. If You are enrolled in Medicare, You are not eligible to purchase this Policy. Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.

We offer the following types of coverage:

1. Individual. If You selected individual coverage, then You are covered.

2. Individual and Spouse. If You selected individual and Spouse coverage, then You and Your Spouse are covered.

3. Parent and Child/Children. If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.

4. Family. If You selected family coverage, then You, Your Spouse, and Your Child or Children, as described below are covered.

5. Catastrophic. If Your selected catastrophic coverage, You must meet one of the following:
    - Be under the age of 30 on the first day of the Policy Year; or
    - Have received a certificate of exemption because of hardship or lac of affordable coverage

C. Children Covered Under this Policy.

If You selected parent and child/children or family coverage, Children covered under this Policy include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal

guardian by a court order. Foster Children and grandchildren are not covered unless required by law or court order.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Policy at any time.

D. Open Enrollment.

You can enroll under this Policy during an open enrollment period that runs from November 1 of the prior calendar year through December 15 of the following calendar year. If the Exchange receives Your selection on or before December 15 of the prior calendar year, Your coverage will begin on January 1 of the following calendar year, as long as the applicable Premium payment is received by then.

If You do not enroll during open enrollment, or during a special enrollment period as described below, You must wait until the next annual open enrollment period to enroll.

E. Special Enrollment Periods.

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child can enroll for coverage within 60 days prior to or after the occurrence of one (1) of the following events:

1. You, Your Spouse or Child involuntarily loses minimum essential coverage, including COBRA or state continuation coverage; including if You are enrolled in a non-calendar year group health plan or individual health insurance coverage, even if You have the option to renew the coverage;

2. You, Your Spouse or Child are determined newly eligible for advance payments of the Premium Tax Credit because the coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, including as a result of Your employer discontinuing or changing available coverage within the next 60 days, provided that You are allowed to terminate existing coverage;
3. You, Your Spouse or Child loses eligibility for Medicaid coverage, including Medicaid coverage for pregnancy-related services and Medicaid coverage for the medically needy, but not including other Medicaid programs that do not provide coverage for primary and specialty care; or
4. You, Your Spouse or Child become eligible for new qualified health plans because of a permanent move and You, Your Spouse or Child either had minimum essential coverage for one (1) or more days during the 60 days before the move or were living outside the United States or a United States territory at the time of the move.

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child can enroll for coverage within 60 days after the occurrence of one (1) of the following events:

1. You, Your Spouse or Child's enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by the Exchange;
2. You, Your Spouse or Child adequately demonstrate to the Exchange that another qualified health plan in which You were enrolled substantially violated a material provision of its contract;
3. You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption or foster care, or through a child support order or other court order, however, foster Children are not covered under this Policy;
4. You lose a Dependent or are no longer considered a Dependent through divorce, legal separation, or upon the death of You or Your Dependents;
5. If You are an Indian, as defined in 25 U.S.C. 450b(d), You may enroll in a qualified health plan or change from one (1) qualified health plan to another one (1) time per month;
6. You, Your Spouse or Child demonstrate to the Exchange that You meet other

exceptional circumstances as the Exchange may provide;

7. You, Your Spouse or Child were not previously a citizen, national, or lawfully present individual and You gain such status; or
8. You, Your Spouse or Child are determined newly eligible or newly ineligible for advance payments of the Premium Tax Credit or have a change in eligibility for Cost-Sharing Reductions.

The Exchange must receive notice and We must receive any Premium payment within 60 days of one (1) of these events.

If You, Your Spouse or Child enroll because You are losing minimum essential coverage within the next 60 days, You are determined newly eligible for advance payments of the Premium Tax Credit because the coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, or You gain access to new qualified health plans because You are moving, and Your selection is made on or before the triggering event, then Your coverage will begin on the first day of the month following Your loss of coverage.

If You, Your Spouse or Child enroll because You got married, Your coverage will begin on the first day of the month following Your selection of coverage. If You, Your Spouse or Child enroll because You gain a Dependent through adoption or placement for adoption, Your coverage will begin on the date of the adoption or placement for adoption. If You, Your Spouse or Child enroll because of a court order, Your coverage will begin on the date the court order is effective.

If You have a newborn or adopted newborn Child and the Exchange receives notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which the Exchange receives notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify the Exchange of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date

on which the Exchange receives notice, provided that You pay any additional Premium when due.

If You, Your Spouse or Child enroll because of the death of You or Your Dependents, Your coverage will begin on the first day of the month following Your selection.

Advance payments of any Premium Tax Credit and Cost-Sharing Reductions are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month.

In all other cases, the effective date of Your coverage will depend on when the Exchange receives Your selection. If Your selection is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is received by then. If Your selection is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month, as long as Your applicable Premium payment is received by then.

F. Special Enrollment Period for Pregnant Women.

If You are pregnant as certified by a Health Care Professional, You may enroll in coverage at any time during Your pregnancy. You must provide Us with the certification from Your Health Care Professional that You are pregnant. Coverage will be effective on the first day of the month in which You received the certification from Your Health Care Professional that You are pregnant unless You elect for coverage to be effective on the first day of the month following certification. You must pay all Premiums due from the first day of the month in which You received the certification that You are pregnant for Your coverage to begin. However, if You elect for coverage to be effective on the first day of the month following certification, You must pay all Premiums due from the first day of the month in which Your coverage is effective.

If You are eligible, advance payments of any Premium Tax Credit and Cost-Sharing Reductions will apply on the first day of the month following Your enrollment with Exchange.

G. Domestic Partner Coverage.

This Policy covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under this Policy also include the Children of

SECTION 5: WHO IS COVERED

Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or

2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
    a. The affidavit must be notarized and must contain the following:
        - The partners are both 18 years of age or older and are mentally competent to consent to contract;
        - The partners are not related by blood in a manner that would bar marriage under the laws of the State of Tennessee;
        - The partners have been living together on a continuous basis prior to the date of the application;
        - Neither individual has been registered as a member of another domestic partnership within the last six (6) months; and
    b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
    c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
        - A joint bank account;
        - A joint credit card or charge card;
        - Joint obligation on a loan;
        - Status as an authorized signatory on the partner's bank account, credit card or charge card;
        - Joint ownership of holdings or investments;
        - Joint ownership of residence;
        - Joint ownership of real estate other than residence;
        - Listing of both partners as tenants on the lease of the shared residence;
        - Shared rental payments of residence (need not be shared 50/50);
        - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
        - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared

50/50);

- Shared household budget for purposes of receiving government benefits;
- Status of one (1) as representative payee for the other's government benefits;
- Joint ownership of major items of personal property (e.g., appliances, furniture);
- Joint ownership of a motor vehicle;
- Joint responsibility for child care (e.g., school documents, guardianship);
- Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
- Execution of wills naming each other as executor and/or beneficiary;
- Designation as beneficiary under the other's life insurance policy;
- Designation as beneficiary under the other's retirement benefits account;
- Mutual grant of durable power of attorney;
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION 6: PREVENTIVE CARE

Please refer to Your Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Preventive Care.

We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Network Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF), or if the immunizations are recommended by the Advisory Committee on Immunization Practices (ACIP). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply.

You may contact Us at 855-OSCAR-55 or visit Our website at www.hioscar.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP. You may also visit the following federal government websites for more information:

- http://www.healthcare.gov/center/regulations/prevention.html
- http://www.ahrq.gov/clinic/uspstfix.htm
- http://www.cdc.gov/vaccines/recs/acip/

A. Well-Baby and Well-Child Care.

We Cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per Benefit Period, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age nine (9) and is not subject to Copayments, Deductibles or Coinsurance when

provided by a Network Provider.

B. Adult Annual Physical Examinations.

We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the Covered preventive Services is available on Our website at www.hioscar.com, or will be mailed to You upon request.

You are eligible for a physical examination once every Benefit Period, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Network Provider.

C. Adult Immunizations.

We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Network Provider.

D. Well-Woman Examinations.

We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at www.hioscar.com, or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above, and

when provided by a Network Provider.

E. Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.

We Cover mammograms for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age 35 through 39; and
- One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We Cover mammograms and BRCA counseling about genetic testing as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Network Provider.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Copayments, Deductibles or Coinsurance when provided by a Network Provider.

F. Family Planning and Reproductive Health Services.

We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug Coverage section of this Policy, counseling on use of contraceptives and related topics, and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Network Provider.

We also Cover vasectomies subject to Copayments, Deductibles or Coinsurance.

We do not Cover services related to the reversal of elective sterilizations.

G. Bone Mineral Density Measurements or Testing.

We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes.

Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Policy. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for Coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Network Provider.

H. Screening for Prostate Cancer.

We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

I. Smoking Cessation.

We Cover a screening for tobacco use and, for those who use tobacco products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:

- Four (4) 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 tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a Health Care Professional without Prior Authorization.

SECTION 7: AMBULANCE AND PRE-HOSPITAL EMERGENCY MEDICAL SERVICES

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

We Cover Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Coinsurance. In the absence of negotiated rates, We will pay a Non-Network Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable.

We also Cover emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed.

We Cover Pre-Hospital Emergency Medical Services and emergency ambulance transportation worldwide.

B. Non-Emergency Ambulance Transportation.

We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a Non-Network Hospital to a Network Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

C. Limitations/Terms of Coverage

- We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
    - The point of pick-up is inaccessible by land vehicle; or
    - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

SECTION 8: EMERGENCY AND URGENT CARE SERVICES

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Emergency Care (including Emergency Room Services)

We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital. For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Network Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or Stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. **However, only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department**.

   We do not Cover follow-up care or routine care provided in a Hospital emergency department. You should contact Us to make sure You receive the appropriate follow-up care.

2. **Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital, You or someone on Your behalf must notify Us at the number on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

3. **Payments Relating to Emergency Services Rendered.** The amount We pay a Non-Network Provider for Emergency Services will be the amount We have negotiated with the Non-Network Provider for the Emergency Service or an amount We have determined is reasonable for the Emergency Service. However, the amount negotiated or the amount We determine is reasonable will not exceed the Non-Network Provider's charge and will be at least the greater of: 1) the amount We have negotiated with Network Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 2) 100% of the Allowed Amount for services provided by a Non-Network Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Network Providers); or 3) the amount that would be paid under Medicare.

   If a dispute involving a payment for Physician Services is submitted to an independent dispute resolution entity (IDRE), We will pay the amount, if any, determined by the IDRE for Physician Services.

   You are responsible for any Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Network Provider charges that exceed Your Copayment, Deductible or Coinsurance.

B. Urgent Care

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. However, You must obtain Urgent Care services from a Network Provider to receive maximum benefits. Urgent Care Services received from a Non-Network Provider will be covered as a Non-Network service and You will be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. If You experience an accidental injury or a medical problem, We will determine whether Your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on Your symptoms.

SECTION 8: EMERGENCY AND URGENT CARE SERVICES

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. If You call Your Physician prior to receiving care for an urgent medical problem and Your Physician authorizes You to go to an emergency room, Your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

If Urgent Care results in an emergency admission, please follow the instructions for emergency Hospital admissions described above.

SECTION 9: OUTPATIENT COVERED SERVICES

Please refer to the Schedule of Benefits for Cost-Sharing requirements, Limitations, and any Preauthorization or Referral requirements that apply to these benefits. All services must be Medically Necessary in order to be Covered.

Outpatient Services include both Facility and ancillary use, and professional charges when given as an Outpatient at a Hospital, alternative care Facility, retail health clinic, or other Provider as determined by the Us. These Facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or Rehabilitation, or other Provider Facility as determined by Us. Professional charges only include services billed by a Physician or other Health Care Professional.

When Diagnostic Services or other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) are the only Outpatient services charge, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

A. Allergy Testing.

We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including injections and serums.

B. Chemotherapy.

We Cover chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents.

C. Chiropractic Services.

We Cover chiropractic care when performed by a Doctor of Chiropractic (chiropractor) in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Policy.

D. Cancer Clinical Trials.

Benefits are available for services for routine patient care rendered as part of a

cancer clinical trial if the services are otherwise Covered Services under this Policy and the clinical trial meets all of the following criteria:

- The purpose of the trial is to test whether the intervention potentially improves the trial participant's health or the treatment is given with the intention of improving the trial participants health, and is not designed simply to test toxicity or disease pathophysiology;
- The trial does one of the following:
    - Tests how to administer a health care service, item, or drug for the treatment of cancer;
    - Tests responses to a health care service, item, or drug for the treatment of cancer;
    - Compares the effectiveness of health care services, items, or drugs for the treatment of cancer; or
    - Studies new uses of health care services, items, or drugs for the treatment of cancer;
- The trial is approved by one of the following:
    - The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services;
    - The FDA;
    - The United States Department of Defense; or
    - The United States Department of Veteran's Affairs.

Benefits do not, however, include the following:

- A health care service, item, or drug that is the subject of the cancer clinical trial or is provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;
- A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

E. Dental Services

Accidental

We Cover dental services for dental work and oral surgery if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of accident only. These services must not be excessive in scope, duration, or intensity. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- oral examinations.
- x-rays.
- tests and laboratory examinations.
- restorations.
- prosthetic services.
- oral surgery.
- mandibular/maxillary reconstruction.
- anesthesia.

Other

We Cover Facility charges for Outpatient services for dental expenses that are Covered Services. Benefits are payable for the removal of teeth or for other dental processes only if Your medical condition or the dental procedure requires a Hospital setting to ensure Your safety.

Pediatric

See the Pediatric Dental Care section of this Policy for Covered pediatric services.

F. Dialysis.

We Cover dialysis treatments of an Acute or chronic kidney ailment, which may include the supportive use of an artificial kidney machine.

G. Habilitation Services.

We Cover Habilitation Services. See Rehabilitation Services below for details and limits.

H. Home Health Care.

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

Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- Medical/Social services.
- Diagnostic Services.
- Nutritional guidance.
- Home Health Aide Services. Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for ChiroTherapy, which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).
- Private Duty Nursing.

Covered Services do not include:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.

- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

I. Infertility Treatment.

We Cover diagnostic and exploratory procedures to determine infertility, including surgical procedures to correct diagnosed diseases or conditions.

J. Interruption of Pregnancy.

We Cover therapeutic abortions. A therapeutic abortion is one performed to save the live or health of the mother or in cases of rape or incest.

K. Infusion Therapy.

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

We cover home infusion therapy if You obtain preauthorization (if applicable). Benefits for home infusion therapy include a combination of nursing, DME and Drug services which are delivered and administered intravenously in the home. Home infusion therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain management and chemotherapy. Any visits for home infusion therapy count toward Your home health care visit limit.

L. Laboratory Procedures and Radiology Services.

We Cover x-ray and laboratory procedures, testing, services and materials, including x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

M. Maternity and Newborn Care.

We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. We will not pay for duplicative routine services provided by both a midwife and a

Physician. See the Inpatient Services section of this Policy for coverage of Inpatient maternity care.

If the You are pregnant on Your when coverage begins and are in the first trimester of the pregnancy, You must change to a Network Provider to have Covered Services paid at the Network level. If You are pregnant when coverage begins and are in Your second or third trimester of pregnancy (13 weeks or later), You may continue obstetrical care with Your Non-Network Provider through the end of the pregnancy and the immediate post-partum period. However, You must notify Us of Your intention to remain with Your Non-Network Provider.

We Cover breastfeeding support, counseling and supplies, including the cost of renting or the purchase of one (1) breast pump per Benefit Period from a Network Provider or designated vendor.

N. Medications for Use in the Office.

We Cover medications and injectables (excluding self-injectables) used by Your Provider in the Provider's office for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Policy.

O. Office Visits.

We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include Home Visits.

P. Outpatient Hospital Services.

We Cover Hospital services and supplies as described in the Inpatient Services section of this Policy that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

Q. Preadmission Testing.

We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;

- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

R. Rehabilitation Services.

We Cover Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy when rendered as Physician Home Visits and Office Services or Outpatient Services. When rendered in the home, Home Care Services limits apply. We also cover Manipulation Therapy for up to 12 visits per Plan Year.

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- Physical therapy including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part.
    - Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- Speech therapy for the correction of a speech impairment.
- Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role.
    - Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could

be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

- Manipulation Therapy includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

S. Second Opinions.

1. Second Cancer Opinion. We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.

2. Second Surgical Opinion. We Cover a second surgical opinion by a qualified Physician on the need for surgery.

3. Required Second Surgical Opinion. We may require a second opinion before We preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
    - The second opinion must be given by a board certified Specialist who personally examines You.
    - If the first and second opinions do not agree, You may obtain a third opinion.
    - The second and third opinion consultants may not perform the surgery on You.

4. Second Opinions in Other Cases. There may be other instances when You will

disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will preauthorize; approve Covered Services supported by a majority of the Providers reviewing Your case.

T. Surgical Services.

We Cover Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services including but not limited to:

- Performance of accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

U. Reconstructive Breast Surgery.

We Cover reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

V. Other Reconstructive and Corrective Surgery.

We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

- Performed to correct significant deformities caused by congenital or developmental abnormalities, illness, injury, or an earlier treatment in order to create a more normal appearance;
- Performed to restore symmetry after a mastectomy;
- Needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan; or
- Otherwise Medically Necessary.

W. Temporomandibular 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.

X. Transplants.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- Cornea and kidney transplants; and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine Your eligibility as a candidate for transplant by Your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by Us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact Us

for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility.

Prior Approval and Precertification

In order to maximize Your benefits, We strongly encourage You to call Us to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. We will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Even if We issue a prior approval for the Covered Transplant Procedure, You or Your Provider must call Us for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Please note that there are instances where Your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination may be made for the transplant procedure.

Transportation and Lodging

We will provide assistance with reasonable and necessary travel expenses as determined by Us when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Interim visits to a medical care facility while waiting for the actual transplant procedure,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation

SECTION 10: ADDITIONAL BENEFITS, EQUIPMENT AND DEVICES

Please refer to the Schedule of Benefits section for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Autism Spectrum Disorder.

We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

1. Screening and Diagnosis. We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

2. Assistive Communication Devices. We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We do not Cover items, such as, but not limited to, laptop, desktop or tablet computers. We Cover software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

   We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft. Coverage will be provided for the device most appropriate to Your

current functional level. We do not Cover delivery or service charges or routine maintenance.

3. Behavior Health Treatment. We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by a licensed or certified applied behavior analysis Health Care Professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

4. Psychiatric and Psychological Care. We Cover direct or consultative services provided by a psychiatrist, psychologist or a licensed clinical social worker with the experience required by Tennessee Insurance Law, licensed in the state in which they are practicing.

5. Therapeutic Care. We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Policy. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Policy.

6. Pharmacy Care. We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Tennessee Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Policy.

7. Limitations. We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under Tennessee Law.

   You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Policy for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this Policy for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

   Nothing in this Policy shall be construed to affect any obligation to provide coverage for otherwise-Covered Services solely on the basis that the services constitute early intervention program services pursuant to Tennessee Insurance Law.

B. Diabetic Equipment, Supplies and Self-Management Education.

We Cover equipment, supplies, and self-management education (as described below) for a Member with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

1. Equipment and Supplies.

We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Health Care Professional legally authorized to prescribe:

- Acetone reagent strips

- Acetone reagent tablets
- Alcohol or peroxide by the pint
- Alcohol wipes
- All insulin preparations
- Automatic blood lance kit
- Blood glucose kit
- Blood glucose strips (test or reagent)
- Blood glucose monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the pump
- Glucagon for injection to increase blood glucose concentration
- Glucose acetone reagent strips
- Glucose reagent strips
- Glucose reagent tape
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin cartridge delivery
- Insulin infusion devices
- Insulin pump
- Lancets
- Oral agents such as glucose tablets and gels
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as Tennessee law designates as appropriate for the treatment of diabetes.

Diabetic equipment and supplies are Covered only when obtained from a designated diabetic equipment or supply manufacturer which has an agreement with Us to provide all diabetic equipment or supplies required by law for Members through Network pharmacies. If You require a certain item not available from Our designated diabetic equipment or supply manufacturer, You or Your Provider must submit a request for a medical exception by calling 855-OSCAR-55. Our medical director will make all medical exception determinations.

2. Self-Management Education.

Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We Cover education on self- management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By Health Care Professional authorized to prescribe under applicable state law, or their staff during an office visit;
- Upon the Referral of Your Physician or other Health Care Professional authorized to prescribe under applicable state law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

3. Limitations.

The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

C. Durable Medical Equipment and Braces.

We Cover the rental or purchase of durable medical equipment and braces.

1. Durable Medical Equipment.

   The rental (or, at Our option, the purchase) of Durable Medical Equipment prescribed by a Physician or other Provider. Durable Medical Equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only

when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Covered Services may include, but are not limited to:

- Hemodialysis equipment;
- Crutches and replacement of pads and tips;
- Pressure machines;
- Infusion pump for IV fluids and medicine;
- Glucometer;
- Tracheotomy tube;
- Cardiac, neonatal and sleep apnea monitors;
- Augmentive communication devices are covered when We approved based on the Member's condition.

Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment. We do not Cover over-the-counter durable medical equipment.

We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.

2. Braces and Orthotic Devices.
Covered Services are 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. The cost of

casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Covered orthotic devices may include, but are not limited to:

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

Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

D. Hospice.

Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician. Covered Services will continue if the Member lives longer than six (6) months.

When approved by Your Physician, 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 (benefits will not be covered for equipment when the Member is in a Facility that should provide such equipment).
- Counseling services.
- Inpatient confinement at a Hospice.

- Prescription Drugs given by the Hospice.
- Home health aide.

E. Medical Supplies.

Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the supplies, equipment or appliances are not received from the Pharmacy's Mail Service or from a Network Pharmacy. Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Prescription Drugs and biologicals that cannot be self administered are provided in a Physician's office. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

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

F. Prosthetics.

We Cover Prosthetics that are artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

- Replace all or part of a missing body part and its adjoining tissues; or
- Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

- Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased

bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.

- Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
- Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
- Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
- Cochlear implant.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis)
- Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).

Coverage is for standard equipment only.

SECTION 11: INPATIENT SERVICES

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Hospital Services.

We Cover Inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x- ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days.

B. Observation Services.

We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or

discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient Medical Services.

We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Policy.

D. Inpatient Stay for Maternity Care.

We Cover Inpatient maternity care in a Hospital for the mother, and Inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal vaginal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also cover any additional days of such care that We determine are Medically Necessary. If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission, apart from the Maternity and ordinary routine nursery admission. Separate Inpatient Cost-Sharing will apply.

If the mother or newborn are discharged prior to the expiration of the applicable number of hours of Inpatient care required to be covered, follow-up care will be covered and provided within 72 hours after discharge. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if Your attending Physician determines further Inpatient postpartum care is not necessary for You or Your newborn child, provided the following are met and the mother concurs:

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

discharge; and
- the availability of post-discharge follow-up to verify the condition of the infant after discharge.

Covered Services include at-home postdelivery care visits at Your residence by a Physician or Nurse performed no later than 72 hours following You and Your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

- parent education;
- assistance and training in breast or bottle feeding; and
- performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for You or Your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At Your discretion, this visit may occur at the Physician's office.

Physician-directed follow-up care after delivery is also covered. Services covered as follow-up care include physical assessment of the mother and newborn, 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. The coverage applies to services provided in a medical setting or through home health care visits. Home health care visit are Covered only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

E. Inpatient Stay for Mastectomy Care.

We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

F. Habilitation Services.

We Cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy. Please see the Schedule of Benefits for visit limits.

G. Rehabilitation Services.

We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy. Please see the Schedule of Benefits for visit limits.

We Cover speech and physical therapy only when:

1. Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
2. The therapy is ordered by a Physician; and
3. You have been hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:

1. The date of the injury or illness that caused the need for the therapy;
2. The date You are discharged from a Hospital where surgical treatment was rendered; or
3. The date outpatient surgical care is rendered.

H. Skilled Nursing Facility.

We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room. Custodial, convalescent or Domiciliary Care is not Covered (see the Exclusions section of this Policy). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. Please see the Schedule of Benefits for benefit limits.

I. Limitations/Terms of Coverage.

1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.
3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive inpatient care, unless Our

denial is overturned by an External Appeal Agent.

SECTION 12: BEHAVIORAL HEALTH SERVICES

Behavioral Health Services also includes coverage for Behavioral Health Conditions and Biologically Based Mental Illness services. Biologically Based Mental Illness means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

We cover intermediate levels of care, such as residential treatment, partial hospitalization and intensive outpatient services.

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

This Plan is compliant with the Mental Health Parity and Equity Act.

SECTION 13: PRESCRIPTION DRUG COVERAGE

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Covered Prescription Drugs.

We Cover Medically Necessary Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Not Experimental/Investigative;
- Determined by Us to be appropriate in quantity;
- Determined by Us to be appropriate for Your age;
- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines; and
- Dispensed by a licensed, Network pharmacy.

Cover Prescription Drugs Benefits include but are not limited to the following:

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs, injectable contraceptive drugs and patches are covered when obtained through an eligible Pharmacy. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.
- Injectables.

Non Covered Prescription Drug Benefits include:

- Prescription Drugs dispensed by any Mail Service program other than Our Pharmacy Benefit Manager's Mail Service, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This Exclusion does not apply to over-the-counter products that We must cover under federal law with a Prescription.
- Off label use, unless approved by Us or the PBM or when the drug has been

recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States Department of Health and Human Services or in medical literature that meets certain criteria. Medical literature may be accepted only if all of the following apply: (1) Two articles from major peer-reviewed professional medical journals have recognized the drug's safety and effectiveness for treatment of the indication for which it has been prescribed; (2) No article from a major peer-reviewed professional medical journal has concluded that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; (3) Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States Department of Health and Human Services as acceptable peer-reviewed medical literature.

- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA.
- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
- Any Drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities which exceed the limits established by the Plan, or which exceed any age limits established by Us.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.
- Oral immunizations and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Services.
- Human Growth Hormone for children born small for gestational age. It is

only a Covered Service in other situations when allowed by Us through Prior Authorization.
- Compound Drugs unless there is at least one ingredient that requires a prescription.
- Drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products.
- Treatment of Onchomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact Us for additional information on these Drugs.
- Refills of lost or stolen medications.
- Certain Prescription Drugs may not be covered when clinically equivalent alternatives are
- available, unless otherwise required by law.

You may call Us at the number on Your ID card to request a copy of Our Formulary for a list of Covered Prescription Drugs, or to inquire if a specific drug is Covered under this Policy. Our Formulary is also available on Our website at www.hioscar.com.

B. Refills.

We Cover Refills of Prescription Drugs only when dispensed at a retail or mail order pharmacy as ordered by an authorized Provider and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one (1) year from the original prescription date.

C. Benefit and Payment Information.

Cost-Sharing Expenses. You are responsible for paying the costs outlined in the Schedule of Benefits section of this Policy when Covered Prescription Drugs are obtained from a retail or mail order pharmacy.

You have a three (3) tier plan design, which means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier 1 and highest for Prescription Drugs on tier 3. Your out-of-pocket expense for Prescription Drugs on tier 2 will generally be more than for tier 1 but less than tier 3.

An additional charge may apply when a Prescription Drug on a higher tier is dispensed at Your or Your Provider's request, when a chemically equivalent Prescription Drug is available on a lower tier unless We approve coverage at the

higher tier. You will have to pay the difference between the cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference must be paid in addition to the lower tier Copayment or Coinsurance.

You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug, and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

Network Pharmacies. For Prescription Drugs purchased at a retail or mail order Network Pharmacy, You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

In the event that Our Network Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Network Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required in-network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at the number on Your ID card to request approval.

Non-Network Pharmacies. We will not pay for any Prescription Drugs that You purchase at a Non-Network retail or mail order Pharmacy other than as described above.

Designated Pharmacies. If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

If You are directed to a Designated Pharmacy and You choose not to obtain Your Prescription Drug from a Designated Pharmacy, You will not have Coverage for that Prescription Drug.

Mail Order. You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Prescription Drug Cost for the Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three (3) Refills). You will be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number of days supply written on the Prescription Order or Refill.

Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy has a participation agreement with Us or Our vendor in which it agrees to be bound by the same terms and conditions as a Network mail order pharmacy.

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at www.hioscar.com or by calling the number on Your ID card.

Tier Status. The tier status of a Prescription Drug may change periodically. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Drug as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at www.hioscar.com or by calling the number on Your ID card.

When a Brand Name Drug Becomes Available as a Generic Drug. When a Brand-

Name Drug becomes available as a Generic Drug, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You no longer have benefits for that particular Brand-Name Drug. Please note, if You are taking a Brand-Name Drug that is being excluded due to a Generic Drug becoming available, You will receive advance written notice of the Brand-Name Drug exclusion. If coverage is denied, You are entitled to an Appeal as outlined in the Utilization Review and Complaints, Appeals and External Review sections of this Policy.

Formulary Exception Process. If a Prescription Drug is not on Our Formulary, You, Your designee or Your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. The request should include a statement from Your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects. If coverage is denied under Our standard or expedited Formulary exception process, You are entitled to an external appeal as outlined in the Complaints, Appeals and External Review section of this Policy. Visit Our website at www.hioscar.com or call 855-OSCAR-55 to find out more about this process.

Standard Review of a Formulary Exception. We will make a decision and notify You or Your designee and the prescribing Health Care Professional no later than 72 hours after Our receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

Expedited Review of a Formulary Exception. If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of treatment using a non-Formulary Prescription Drug, You may request an expedited review of a Formulary exception. The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify You or Your designee and the prescribing Health Care Professional no later than 24 hours after Our receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

Supply Limits. We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a 30-day supply. However, for Maintenance Drugs We will pay for up to a 90-day supply of a drug purchased at a retail pharmacy. You are responsible for up to three (3) Cost-Sharing amounts for a 90-day supply at a retail pharmacy.

Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a maximum of three (3) Cost-Sharing amounts for a 90-day supply.

Specialty Prescription Drugs may be limited to a 30-day supply when obtained at a retail or mail order pharmacy. You may access Our website at www.hioscar.com or by calling the number on Your ID card for more information on supply limits for specialty Prescription Drugs.

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website www.hioscar.com or by calling the number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and Complaints, Appeals and External Review sections of this Policy.

Emergency Supply of Prescription Drugs for Substance Use Disorder Treatment. If You have an Emergency Condition, You may immediately access, without Preauthorization, a five (5) day emergency supply of a Prescription Drug for the treatment of a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. If You have a Copayment, it will be prorated. If You receive an additional supply of the Prescription Drug within the 30-day period in which You received the emergency supply, Your Copayment for the remainder of the 30-day supply will also be prorated. In no event will the prorated Copayment(s) total more than Your Copayment for a 30-day supply.

Cost-Sharing for Orally Administered Anti-Cancer Drugs. All orally administered

cancer medications will be covered on the same basis and at not greater cost sharing than imposed for IV or injected cancer medications.

D. Medical Management.

This Policy includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

Preauthorization. Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug. Should You choose to purchase the Prescription Drug without obtaining Preauthorization, You must pay for the cost of the entire Prescription Drug and submit a claim to Us for reimbursement.

For a list of Prescription Drugs that need Preauthorization, please visit Our website at www.hioscar.com or call the number on Your ID card. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, Including if a Prescription Drug or related item on the list is not Covered under Your Policy. Your Provider may check with Us to find out which Prescription Drugs are Covered.

Step Therapy. Step therapy is a process in which You may need to use one (1) or more types of Prescription Drug before We will Cover another as Medically Necessary. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If coverage is denied, You are entitled to an Appeal as outlined in the Utilization Review and Complaints, Appeals and External Review sections of this Policy.

E. General Conditions.

You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. You must include Your

identification number on the forms provided by the mail order pharmacy from which You make a purchase.

Drug Utilization, Cost Management and Rebates. We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost- effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for Your coverage. We may also, from time to time, enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member's utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Instead, any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of Members. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

SECTION 14: PEDIATRIC VISION CARE

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits and any Preauthorization or Referral requirements that apply to these benefits.

A. Pediatric Vision Care.

We Cover emergency, preventive and routine vision care for Members through the end of the month in which the Member turns 19 years of age.

B. Vision Examinations.

We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time in any 12-month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

C. Prescribed Lenses and Frames.

We Cover standard prescription lenses or contact lenses one (1) time in any 12-month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also Cover standard frames adequate to hold lenses one (1) time in any 12-month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation. If You choose a non-standard frame, We will pay the amount that We would have paid for a standard frame and You will be responsible for the difference in cost between the standard frame and the non-standard frame.

SECTION 15: PEDIATRIC DENTAL CARE

Please refer to the Schedule of Benefits for Cost-Sharing requirements, Limitations, and any Preauthorization or Referral requirements that apply to these benefits. All services must be Medically Necessary in order to be Covered.

A. Pediatric Dental Care.

We Cover the below additional dental care services for Members through the end of the month in which the Member turns 19 years of age.

B. Emergency Dental Care.

We Cover emergency dental care, which includes emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency dental care is not subject to Our Preauthorization.

C. Preventive Dental Care.

We Cover preventive dental care that includes procedures which help to prevent oral disease from occurring, including:

- Prophylaxis (scaling and polishing the teeth) at six (6) month intervals;
- Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
- Sealants on unrestored permanent molar teeth; and
- Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

D. Routine Dental Care.

We Cover routine dental care provided in the office of a dentist, including:

- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
- X-rays, full mouth x-rays or panoramic x-rays at 36-month intervals, bitewing x-rays at six (6) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation; and
- Amalgam, composite restorations and stainless steel crowns.

E. Endodontics.

We Cover routine endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

F. Periodontics.

We Cover limited periodontic services. We Cover non-surgical periodontic services. We Cover periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects. We also Cover periodontic services in anticipation of, or leading to orthodontics that are otherwise Covered under this Policy.

G. Prosthodontics.

We Cover prosthodontic services as follows:

- Removable complete or partial dentures for Members 15 years of age and above, including six (6) months follow-up care;
- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate;
- Interim prosthesis for Members five (5) to 15 years of age; and
- Single crowns, one (1) per tooth every 60 months and crown related services.

We do not Cover implants or implant related services.

Fixed bridges are not Covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

H. Oral Surgery.

We Cover non-routine oral surgery, such as partial and complete bony extractions, tooth re-implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of device to facilitate eruption of an impacted tooth. We also Cover oral surgery in anticipation of, or leading to orthodontics that are otherwise Covered under this Policy.

SECTION 15: PEDIATRIC DENTAL CARE

I. Orthodontics.

We Cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

SECTION 16: EXCLUSIONS

No coverage is available under this Policy for those procedure, equipment, services, supplies, or charges:

- Which We determine are not Medically Necessary.
- Received from an individual or entity that is not a Provider, as defined herein, or recognized by Us.
- Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.
- For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to You, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
- For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- For court ordered testing or care unless Medically Necessary.
- For which You would not be legally required to pay for in the absence of insurance, except for services provided by a non-governmental charitable research hospital.
- For the following:
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for Your care.
    - Charges that are not documented in Provider records.
    - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to

be fitted and adjusted by the attending Physician.
    - For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
- Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- Prescribed, ordered or referred by or received from a member of Your immediate family, including Your spouse, child, brother, sister, parent, in-law, or self.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated.
- For which benefits are payable under Medicare Parts B, and/or D when Medicare is primary. If Medicare is not primary, this exclusion does not apply if a person is or could have been covered under another plan, except with respect to Part B of Medicare.
- Charges in excess of Our Maximum Allowable Amounts for kidney dialysis when traveling.
- Incurred prior to Your Effective Date.
- Incurred after the termination date of this coverage except as specified elsewhere.
- For any procedures, services, equipment or supplies provided in connection with cosmetic services. Complications directly related to cosmetic services treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Policy. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.
- For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves Your present level of functioning and prevents loss

of that functioning, but which does not result in any additional improvement.

- For the following:
  - Custodial Care, convalescent care or rest cures.
  - Domiciliary Care provided in a residential institution, treatment center, supervised living or halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
  - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
  - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, halfway house, or outward bound programs, even if psychotherapy is included.
  - Wilderness camps.
- For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
  - cleaning and soaking the feet.
  - applying skin creams in order to maintain skin tone.
  - other services that are performed when there is not a localized illness, injury or symptom involving the foot.
- For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- For dental treatment, regardless of origin or cause, except as specified elsewhere in this Policy. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:
  - extraction, restoration and replacement of teeth.
  - medical or surgical treatments of dental conditions.
  - services to improve dental clinical outcomes.
- For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
- For Dental implants.
- For Dental braces.
- For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only

exceptions to this are for any of the following:
    - transplant preparation.
    - initiation of immunosuppresives.
    - direct treatment of acute traumatic injury, cancer or cleft palate.
- Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
- Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Policy. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
- For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous Anthem plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self funded plan prior to coverage under this Policy. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post operative time frame.
- For marital counseling.
- For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.
- For vision orthoptic training.
- For hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Policy.
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

- For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or
    - Sports helmets.
- Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
- For telephone consultations or consultations via electronic mail or internet/web site that do not meet the definition of "Telehealth" under section 56-7-1002 of the Tennessee Code , and except as required by law, authorized by Us, or as otherwise described in this Policy.
- For care received in an emergency room which is not Emergency Care, except as specified in this Policy. This includes, but is not limited to suture removal in an emergency room.
- For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
- For self-help training and other forms of non-medical self care, except as otherwise provided in this Policy.
- For examinations relating to research screenings.
- For stand-by charges of a Physician.
- Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
- For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in this Policy.
- For Manipulation Therapy services rendered in the home as part of Home

Care Services.

- Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
- For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
- For any services or supplies provided to a person not covered under the Policy in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- For surgical treatment of gynecomastia.
- For treatment of hyperhidrosis (excessive sweating).
- For any service for which You are responsible under the terms of this Policy to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by Us through Prior Authorization.
- Complications directly related to a service or treatment that is a non Covered Service under this Policy because it was determined by Us to be Experimental/Investigational or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non Medically Necessary service.
- For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This Exclusion does not apply to over-the-counter products that We must cover under federal law with a Prescription.

- Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
- Treatment of telangiectatic dermal veins (spider veins) by any method.
- Reconstructive services except as specifically stated herein, or as required by law.
- Nutritional and/or dietary supplements, except as provided in this Policy or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist. This exclusion does not apply to the treatment of phenylketonuria or other inherited metabolic disease.
- For room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission for Your condition.
- For services related to applied behavior analysis, except as otherwise covered in this Policy.

EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine in Our sole discretion to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by Us to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same

function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We have the authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

SECTION 17: CLAIMS

When You or Your Covered Dependent(s) receive Covered Services from a Network Provider, the Provider will submit a claim to Us. If You receive Covered Services from a Non-Network Provider, either You or the Provider must submit a claim form to Us. If You receive Covered Services from a Non-Network Pharmacy, You must submit a claim form to Us. We will review the claim and let You or the Provider know if We need more information before We pay or deny the claim. We follow Our internal administration procedures when We process claims.

A claim must be filed for You to receive Non-Network Services benefits, but many Non-Network Hospitals, Physicians and other Providers will still submit Your claim for You. If You submit the claim, use a claim form.

A. Assignment.

You cannot legally transfer this Policy, without obtaining written permission from the Plan. Members cannot legally transfer the coverage. Benefits available under this Policy are not assignable by any Member without obtaining written permission from the Plan, unless in a way described in this Policy.

B. Notice of Claim.

We are not liable under the Policy, unless We receive written notice that Covered Services have been given to You. The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for Your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given. If We are unable to complete processing of a claim because You or Your Provider fail to provide Us with the additional information within 60 days of Our request, the claim will be denied. We will reopen and process the claim if You or Your Provider submit

additional information within the timeframes specified below.

Failure to give Us notice within 90 days will not reduce any benefit if You show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid except in the case of fraud by a Provider.

C. Claim Forms.

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for claim forms to Us, or contact customer service and ask for claim forms to be sent to You. If You do not receive the claim forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type and place of service.
- Your signature and the Provider's signature.

D. Member's Cooperation.

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program.

E. Explanation of Benefits (EOB).

After You receive medical care, You will receive an explanation of benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement from Us to help You understand the coverage You are receiving. The EOB shows:

- Total amounts charged for services/supplies received.
- The amount of the charges satisfied by Your coverage.
- The amount for which You are responsible (if any).
- General information about Your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process

SECTION 18: UTILIZATION REVIEW

Utilization review means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

Your Plan includes the processes of Pre-Service, Concurrent and Retrospective Reviews to determine when services should be covered by Your Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Your Plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

A. Prior Authorization.

Network Providers are responsible for obtaining Prior Authorization when required for You to receive benefits. Prior Authorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. We may determine that a service that was initially prescribed or requested is not Medically Necessary if You have not previously tried alternative treatments which are more cost effective.

Prior Authorization requests must be received by phone, fax, in writing or through a secure online portal as follows:

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

If You have any questions regarding the information contained in this section, You may call Us at telephone number on Your Identification Card or visit www.hioscar.com.

B. Types of Requests.

Precertification

A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, You, Your authorized representative or Physician must notify Us within 24 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Predetermination

An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. We will review Your Policy to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service meets the definition of Medical Necessity under this Policy or is Experimental/Investigative as that term is defined in this Policy.

Medical Review

A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not require Precertification and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

C. Request Categories.

Urgent

A request for Precertification or Predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the member to severe pain that cannot be adequately managed without such care or treatment.

If an urgent care review request is not approved, the Member may proceed with an expedited external review while simultaneously pursuing an appeal through Our internal appeal process.

Prospective

A request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.

Concurrent

A request for Precertification or Predetermination that is conducted during the course of treatment or admission. If a concurrent review request is not approved, a Member who is receiving an ongoing course of treatment may proceed with an expedited external review while simultaneously pursuing an appeal through Our internal appeal process.

Retrospective

A request for Precertification that is conducted after the service, treatment or admission has occurred. Medical Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

D. Decision and Notification Requirements.

Timeframes and requirements listed are based on state and federal regulations. Where state regulations are stricter than federal regulations, We will abide by state regulations. If You reside and/or receive services in a state other than the state where Your contract was issued, other state-specific requirements may apply. You may call Us at the telephone number on Your ID Card for more information.

Request Category	Timeframe
Prospective Urgent	72 hours or 2 business days from the receipt of request whichever is less
Prospective Non-Urgent	72 hours or 2 business days from the receipt of request whichever is less
Concurrent Urgent (when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists)	24 hours or 1 business day from the receipt of the request whichever is less
Concurrent Urgent (when request is received more than 24 hours after the expiration of the previous authorization or no previous authorization exists)	72 hours or 1 business day from the receipt of request whichever is less
Concurrent Non-Urgent	72 hours or 1 business day from the receipt of the request whichever is less
Retrospective	30 calendar days from the receipt of the request

If additional information is needed to make Our decision, We will notify the requesting Provider and send written notification to You or Your authorized representative of the specific information necessary to complete the review. If We do not receive the specific information requested or if the information is not complete by the timeframe identified in the written notification, a decision will be made based upon the information in Our possession.

We will provide notification of Our decision in accordance with state and federal regulations. Notification may be given by the following methods:

- Verbal: oral notification given to the requesting Provider via telephone or via electronic means if agreed to by the Provider.
- Written: mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and the Member or authorized Member representative.

SECTION 19: GRIEVANCE PROCEDURE

Our Grievance procedure is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with Us. Such Disputes include any matters that cause You to be dissatisfied with any aspect of Your relationship with Us; any Adverse Benefit Determination concerning a claim; Rescission of Coverage; or any other claim, controversy, or potential cause of action You may have against Us.

A. The Grievance Procedure.

If You have a complaint, problem, or claim concerning benefits or services, please contact Us. Please refer to Your ID Card for Our address and telephone number.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from Us of Our procedures and Your benefit document. You may submit Your complaint by letter or by telephone call. If Your complaint involves issues of Covered Services, You may be asked to sign a release of information form so We can request records for Our review.

You must submit a written request asking Us to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of Dispute (Your "Grievance"). You must begin the Dispute process within one-hundred and eighty (180) days from the date We issue notice of an Adverse Benefit Determination or from the date of the event that is otherwise causing You to be dissatisfied with Us. The Grievance process that was in effect on the date(s) of service for which You received an Adverse Benefit Determination will apply.

You will be notified of the resolution of Your complaint if a claim or request for benefits is denied in whole or in part. We will explain why benefits were denied and describe Your rights under the Appeal Procedure.

B. The Review Procedures.

Inquiry

An inquiry is an informal process that may answer questions or resolve a potential Dispute. You should contact a consumer advisor if You have any questions about how to file a claim or to attempt to resolve any Dispute. Making an inquiry does not stop the time period for filing a claim or beginning a Dispute. You do not have to make an inquiry before filing a Grievance.

Grievance

SECTION 19: GRIEVANCE PROCEDURE

You must submit a written request asking Us to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of Dispute (Your "Grievance"). You must begin the Dispute process within one-hundred and eighty (180) days from the date We issue notice of an Adverse Benefit Determination or from the date of the event that is otherwise causing You to be dissatisfied with Us. If You do not initiate a Grievance within one-hundred and eighty (180) days of when We issue an Adverse Benefit Determination, You may give up the right to take any action related to that Dispute. The Grievance process that was in effect on the date(s) of service for which You received an Adverse Benefit Determination will apply.

Contact Our consumer advisors at the number on the back of Your Member ID card for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance. This is the first level Grievance procedure and is mandatory.

Grievance Hearing

After We have received and reviewed Your Grievance, Our first level Grievance committee will meet to consider Your Grievance and any additional information that You or others submit concerning that Grievance. For Grievances concerning urgent care or pre-service claims, We will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning Your Dispute are not eligible to be voting members of the first level Grievance committee or reviewers. The committee or reviewers have full discretionary authority to make eligibility, benefit and/or claim determinations, pursuant to this Policy.

Written Decision

The committee or reviewers will consider the information presented, and You will receive a written decision concerning Your Grievance as follows:

- For a pre-service claim, within thirty (30) days of receipt of Your request for review;
- For a post-service claim, within sixty (60) days of receipt of Your request for review; and
- For a pre-service, urgent care claim, within seventy-two (72) hours of receipt of Your request for review.

The decision of the committee will be sent to You in writing and will contain:

- A statement of the committee’s understanding of Your Grievance;

- The basis of the committee's decision; and
- Reference to the documentation or information upon which the committee based its decision. We will send You a copy of such documentation or information, without charge, upon written request.

C. Second Level Grievance Procedure.

You may file a written request for reconsideration within ninety (90) days after We issue the first level Grievance committee's decision. This is called a second level Grievance. This step is a voluntary step in the Grievance procedure. Information on how to submit a second level Grievance will be provided to You in the decision letter following the first level Grievance review.

Your decision concerning whether to file a second level Grievance has no effect on Your rights to any other benefits under this Policy. Any person involved in making a decision concerning Your Dispute (e.g. first level committee members) will not be a voting member of the second level Grievance committee.

Grievance Hearing

You may request an in-person or telephonic hearing before the second level Grievance committee. You may also request that the second level Grievance committee reconsider the decision of the first level committee, even if You do not want to participate in a hearing concerning Your Grievance. If You wish to participate, Our representatives will contact You to explain the hearing process and schedule the time, date and place for that hearing.

In either case, the second level committee will meet and consider all relevant information presented about Your Grievance, including:

- Any new, relevant information that You submit for consideration; and
- Information presented during the hearing. Second level Grievance committee members may ask You questions during the hearing. You may make a closing statement to the committee at the end of the hearing.
- If You wish to bring a personal representative with You to the hearing, You must notify Us at least five (5) days in advance and provide the name, address and telephone number of Your personal representative.

Written Decision

After the hearing, the second level committee will meet in closed session to make a decision concerning Your Grievance. That decision will be sent to You in writing. The written decision will contain:

- A statement of the second level committee's understanding of Your Grievance;
- The basis of the second level committee's decision; and
- Reference to the documentation or information upon which the second level committee based its decision. Upon written request, We will send You a copy of any such documentation or information, without charge.

D. Independent Review of Medical Necessity Determinations or Coverage Recissions.

If Your Grievance involves a Medical Necessity, Investigational or Coverage Rescission determination, then either (1) after completion of the mandatory first level Grievance; or (2) after completion of the mandatory first level Grievance immediately followed by completion of the voluntary second level Grievance, You may request that the Dispute be submitted to a neutral third party, selected by Us, to independently review and resolve such Dispute(s). If You request an independent review following the mandatory first level Grievance, You waive Your right to a second level Grievance and Your right to present testimony during the Grievance procedure. Your request for independent review must be submitted in writing within one-hundred and eighty (180) days after the date You receive notice of the committee's decision. Receipt shall be deemed to have occurred no more than two (2) days after the date of issuance of the committee's decision. Any person involved in making a decision concerning Your Dispute will not be a voting member of the independent review panel or committee.

Your decision concerning whether to request independent review has no effect on Your rights to any other benefits under this Policy.

We will pay the fee charged by the independent review organization and its reviewers if You request that We submit a Dispute to independent review. You will be responsible for any other costs that You incur to participate in the independent review process, including attorneys' fees.

We will submit the necessary information to the independent review entity within five (5) business days after receiving Your request for review. We will provide copies of Your file, excluding any proprietary information, to You upon written request. The reviewer may also request additional medical information from You. You must submit any requested information, or explain why that information is not being submitted, within five (5) business days after receiving that request from the reviewer.

The reviewer must make a decision within forty (40) calendar days after receipt of the independent review request. The reviewer must then notify Us within two (2) calendar days of its decision. We will then notify You within three (3) calendar days after receiving the reviewer's decision. In the case of a life-threatening condition, the decision must be issued within seventy-two (72) hours after receiving the review request. Except in cases involving a life-threatening condition, the reviewer may request an extension of up to five (5) business days to issue a determination to consider additional information submitted by You or Us.

The reviewer's decision must state the reasons for the determination based upon (1) the terms of this Policy; (2) Your medical condition; and (3) information submitted to the reviewer. The reviewer's decision may not expand the terms of Coverage of this Policy.

Note: No legal action shall be brought to recover under this Policy until sixty (60) days after proof of loss has been furnished. No such legal action shall be brought more than three (3) years after the time proof of loss is required.

SECTION 20: TERMINATION OF COVERAGE

This Policy may be terminated as follows:

A. Automatic Termination of this Policy.

This Policy shall automatically terminate upon the death of the Subscriber, unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, this Policy will terminate as of the last day of the month for which the Premium has been paid.

B. Automatic Termination of Your Coverage.

Coverage under this Policy shall automatically terminate:

1. For Spouses in cases of divorce, the date of the divorce.
2. For Children, the end of the month in which the Child turns 26 years of age.
3. For all other Dependents, the end of the month in which the Dependent ceases to be eligible, except that We shall not terminate Your Dependent if Your Dependent becomes eligible for or enrolls in Medicare.

C. Termination by You.

The Subscriber may terminate this Policy at any time by giving the Exchange 14 days' prior written notice.

D. Termination by Us.

We may terminate this Policy with 30 days' written notice as follows:

1. Non-Payment of Premiums. Premiums are to be paid by the Subscriber to Us on each Premium due date. While each Premium is due by the due date, there is a grace period for each Premium payment. If the Premium payment is not received by the end of the grace period, coverage will terminate as follows:
    - If the Subscriber does not receive advanced payments of the Premium Tax Credit for coverage in the Exchange and fails to pay the required Premium within a 30-day grace period, this Policy will terminate retroactively back to the last day Premiums were paid. The Subscriber will be responsible for paying any claims submitted during the grace period if this Policy terminates.
    - If the Subscriber receives advanced payments of the Premium Tax Credit and has paid at least one (1) full month's Premium, this Policy will terminate one (1) month after the last day Premiums were paid. That is, retroactive termination will not exceed 61 days. We may pend claims incurred during the 61-day grace period. The Subscriber will be

responsible for paying any claims incurred during the 61-day grace period if this Policy terminates.

2. Fraud or Intentional Misrepresentation of Material Fact. If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or the Subscriber has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, this Policy will terminate immediately upon a written notice to the Subscriber and/or the Subscriber's Dependent, as applicable, from the Exchange. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application, We will rescind this Policy if the facts misrepresented would have led Us to refuse to issue this Policy and the application is attached to this Policy. Rescission means that the termination of Your coverage will have a retroactive effect of up to the issuance of this Policy. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

3. If the Subscriber no longer lives or resides in Our Service Area.

4. The date the Policy is terminated because We stop offering the class of policies to which this Policy belongs, without regard to claims experience or health related status of this Policy. We will provide the Subscriber with at least 90 days' prior written notice.

5. The date the Policy is terminated because We terminate or cease offering all hospital, surgical and medical expense coverage in the individual market, in this State. We will provide the Subscriber with at least 180 days' prior written notice.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

E. Rescission.

A rescission of Your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide You with coverage, just as if You never had coverage under the Plan. Your coverage can only be rescinded if You (or a person seeking coverage on Your behalf), performs an act, practice, or omission

that constitutes fraud; or unless You (or a person seeking coverage on Your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of Your Plan.

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

SECTION 21: TEMPORARY SUSPENSION RIGHTS FOR ARMED FORCES' MEMBERS

If You, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. You serve no more than five (5) years of active duty.

You must make written request to Us to have Your coverage suspended during a period of active duty. Your unearned Premiums will be refunded during the period of such suspension.

Upon completion of active duty, Your coverage may be resumed as long as You:

1. Make written application to Us; and
2. Remit the Premium within 60 days of the termination of active duty.

The right of resumption extends to coverage for Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION 22: CONVERSION RIGHT TO A NEW POLICY AFTER TERMINATION

A. Circumstances Giving Rise to Right to Conversion.

The Subscriber's Spouse and Children have the right to convert to a new Policy if their coverage under this Policy terminates under the circumstances described below.

1. Termination of Your Marriage. If a Spouse's coverage terminates under the Termination of Coverage section of this Policy because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Policy as a direct payment member.
2. Termination of Coverage of a Child. If a Child's coverage terminates under the Termination of Coverage section of this Policy because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Policy as a direct payment member.
3. On the Death of the Subscriber. If coverage terminates under the Termination of Coverage section of this Policy because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Policy as direct payment members.

B. When to Apply for the New Policy.

If You are entitled to purchase a new Policy as described above, You must apply to Us for the new Policy within 60 days after termination of Your coverage under this Policy. You must also pay the first Premium of the new Policy at the time You apply for coverage.

C. The New Policy.

We will offer You an individual direct payment Policy at each level of coverage (i.e., bronze, silver, gold or platinum) that Covers all benefits required by state and federal law. You may choose among any of the Policies offered by Us.

SECTION 23: GENERAL PROVISIONS

1. Agreements Between Us and Network Providers.
Any agreement between Us and Network Providers may only be terminated by Us or the Providers. This Policy does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Network Provider or any health benefits program.

2. Assignment.
You or other Members covered under this Policy may assign any benefits under this Policy to Your health care Provider. Notice of the assignment must be in writing to Us in order to be effective.We may disregard Your assignment if the assignment of benefits is to a Non-Network Facility-based Physician and the conditions of section 56-7-120 of the Tennessee Code are not satisfied.

3. Changes in this Policy.
We may unilaterally change this Policy upon renewal, if We give You 45 days' prior written notice.

4. Choice of Law.
This Policy shall be governed by the laws of the State of Tennessee.

5. Clerical Error.
Clerical error, whether by You or Us, with respect to this Policy, or any other documentation issued by Us in connection with this Policy, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. Conformity with Law.
Any term of this Policy which is in conflict with Tennessee State law or with any applicable federal law that imposes additional requirements from what is required under Tennessee State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.
Some of the benefits in this Policy may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage

status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

8. Continuation of Coverage.
If the Plan is discontinued prior to the expiration of the Benefit Period, We may extend health care services to You. Please contact Us at the number on Your ID Card for more information.

9. Entire Agreement.
This Policy, including any endorsements, riders and the attached applications, if any, constitutes the entire Policy.

10. Furnishing Information and Audit.
All persons covered under this Policy will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Policy. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care.

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

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

13. Independent Contractors.
Network Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Network Provider. We are not liable for any claim or demand on account of damages arising

out of, or in any manner connected with, any injuries alleged to be suffered by You, Your covered Spouse or Children while receiving care from any Network Provider or in any Network Provider's Facility.

14. Material Accessibility.
We will give You ID cards, Policies, riders and other necessary materials.

15. More Information About Your Health Plan.
You can request additional information about Your coverage under this Policy. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Policy.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with Network Hospitals.
- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines.
- Written application procedures and minimum qualification requirements for Providers.

16. Notice.
Any notice that We give You under this Policy will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: Oscar Insurance, PO Box 52146 Phoenix, AZ 85072-2146.

17. Policy on Third Party Payment of Cost-Sharing and Premium.

The Plan only accepts Premium payments from:

- The Member;
- The Member's family; or
- Entities the law requires the Plan to accept Cost-Sharing payments from, which as of the Effective Date currently are:
  - Ryan White HIV/AIDS programs,
  - Entities required under title XXVI of the Public Health Service Act,
  - Indian tribes, tribal organizations and urban Indian organizations;
  - State and Federal government programs, as described in 45 CFR § 156.1250.

Cost-Sharing payments from any other party, other than those listed above, will not be applied to Your coverage. Premium payments from any party, other than those listed above, will not be credited to Your account which may result in termination or cancellation of coverage in accordance with the Termination provisions of this Policy. If You believe We should accept payment from a party, not listed above, please call Us at 1-855-OSCAR-55 or contact the Tennessee Department of Commernce & Insurance.

If You or Your Authorized Representative has a subrogation or lien inquiry, please send it to oscarmanualreferrals@rawlingscompany.com.

18. Premium Refund.
We will give any refund of Premiums, if due, to the Subscriber.

19. Recovery of Overpayments.
We reserve the right to recover any payments made by Us that were:

- Made in error;
- Made to You or any party on Your behalf, where We determine that such payment made is greater than the amount payable under this Policy;
- Made to You and/or any party on Your behalf, based on fraudulent or misrepresented information; or
- Made to You and/or any party on Your behalf for charges that were discounted, waived or rebated.

We reserve the right to adjust any amount applied in error to the Deductible or Out-of-Pocket Limit.

Our right to recover payments, as specified above, will be limited to 18 months from the date of the payment.

20. Renewal Date.
The renewal date for this Policy is January 1 of each year. This Policy will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Policy or by the Subscriber upon 30 days' prior written notice to Us.

21. Reinstatement After Default.
If the Subscriber defaults in making any payment under this Policy, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Policy.

22. Right to Develop Guidelines and Administrative Rules.
We may develop or adopt standards that describe in more detail when We will or will not make payments under this Policy. Examples of the use of the standards are to determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Policy. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Policy.

23. Right to Offset.
If We make a premium payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other premiums received, We have the right to subtract any amount You owe Us from any payment We owe You.

24. Severability.
The unenforceability or invalidity of any provision of this Policy shall not affect the validity and enforceability of the remainder of this Policy.

25. Significant Change in Circumstances.

If We are unable to arrange for Covered Services as provided under this Policy as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Network Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Network Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

26. Subrogation and Reimbursement.

These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to You under this Policy. Subrogation means that We have the right, independently of You, to proceed directly against the other party to recover the benefits that We have provided.

As a condition to receiving benefits from Us, You agree to transfer to Us any rights You may have to make a claim, take legal action or recover any expenses paid under the Policy. We will be subrogated to Your rights to recover from any funds paid or payable for medical expenses as a result of a personal injury claim or any reimbursement by:

- Any legally liable person or their carrier, including self-insured entities;
- Any uninsured motorist or underinsured motorist coverage;
- Medical payments/expense coverage under any automobile, homeowners, premises or similar coverages;
- Workers' Compensation or other similar coverage; and
- No-fault or other similar coverage.

We may enforce Our subrogation rights by asserting a claim to any coverage to which You may be entitled. If We are precluded from exercising Our rights of subrogation, We may exercise Our right of reimbursement.

You will notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of any settlement, compromise, judgment or Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which

SECTION 23: GENERAL PROVISIONS

We have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

If, after the inception of coverage with Us, You recover payment from and release any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, Workers' Compensation, no-fault, or other similar insurer from liability for future medical expenses relating to a sickness or bodily injury, We will have a continuing right to reimbursement from You to the extent of the benefits We provided with respect to that sickness or bodily injury. This right, however, will apply only to the extent of such payment and only to the extent not precluded or limited by any law or legal doctrine that prohibits an insurer from seeking reimbursement for its expenses until the insured is made whole.

If You or Your Authorized Representative has a subrogation or lien inquiry, please send it to oscarmanualreferrals@rawlingscompany.com.

27. Third Party Beneficiaries.
No third party beneficiaries are intended to be created by this Policy and nothing in this Policy shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Policy. No other party can enforce this Policy's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Policy, or to bring an action or pursuit for the breach of any terms of this Policy.

28. Time to Sue.
No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Policy. You must start any lawsuit against Us under this Policy within three (3) years from the date the claim was required to be filed.

29. Translation Services.
Translation services are available under this Policy for non-English speaking Members. Please contact Us at 855-OSCAR-55 to access these services.

30. Venue for Legal Action.
If a dispute arises under this Policy, it must be resolved in a court located in the State of Tennessee. You agree not to start a lawsuit against Us in a court anywhere

else. You also consent to Tennessee courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

31. Waiver.
The waiver by any party of any breach of any provision of this Policy will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

32. Who May Change this Policy.
This Policy may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer ("CEO") or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Policy in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

33. Who Receives Payment Under this Policy.
Payments under this Policy for services provided by a Network Provider will be made directly by Us to the Provider. If You receive services from a Non-Network Provider, We reserve the right to pay either You or the Provider. If You assign benefits for a surprise bill to a Non-Network Provider, We will pay the Non-Network Provider directly. See the How Your Coverage Works section of this Policy for more information about surprise bills.

34. Workers' Compensation Not Affected.
The coverage provided under this Policy is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

35. Your Medical Records and Reports.
In order to provide Your coverage under this Policy, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Policy, You automatically give Us or Our designee permission to obtain and use Your medical

records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your information with the Tennessee Department of Commerce & Insurance, quality oversight organizations, and third parties with which We contract to assist Us in administering this Policy, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.