Cleveland Clinic + Oscar

This is Your

EVIDENCE OF COVERAGE

Issued by

Oscar Insurance Corporation of Ohio

This is Your individual direct payment Policy for coverage issued by Oscar Insurance Corporation of Ohio. 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 IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

READ THIS ENTIRE POLICY CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS POLICY.

This Policy is not a Medicare supplement Policy. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from Oscar."

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

Mario Schlosser
CEO, Oscar Insurance Corporation
295 Lafayette Street
NY, NY 10012

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SECTION 1: DEFINITIONS

Active Course of Treatment: (A) An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; or (B) An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits; or (C) The second or third trimester of pregnancy, through the postpartum period; or (D) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

Acute: The onset of disease or injury, or a change in the 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: A decision by Oscar:

- To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
    - A determination that the health care service does not meet the Oscar's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
    - A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage;
    - A determination that a health care service is not a covered benefit;
    - The imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.

- Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
- To rescind coverage on a health benefit plan.

Allowed Amount or Maximum Allowable Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing 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 Representative: An individual who represents a covered person in an internal appeal or external review process of an Adverse Benefit Determination who is any of the following:

- A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an Adverse Benefit Determination;
- A person authorized by law to provide substituted consent for a covered individual;
- A family member or a treating health care professional, but only when the covered person is unable to provide consent.

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 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.

Basic Health Care Services: The following services when Medically Necessary:

- Physician's services, except when such services are Supplemental Health Care Services;

- Inpatient hospital services;
- Outpatient medical services;
- Emergency Health Services;
- Urgent Care services;
- Diagnostic laboratory services and diagnostic and therapeutic radiologic services;
- Diagnostic and treatment services, other than Prescription Drug services, for biologically based mental illnesses;
- Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care;
- Routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Revised Code.

Basic health care services does not include Experimental procedures.

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

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

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

Child, Children: The 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. Your Coinsurance does not apply to charges for services which are not covered and will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

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

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

Cost-Sharing Reductions: 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:

- Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
- Preparation and administration of special diets;
- Supervision of the administration of medication by a caregiver;
- Supervision of self-administration of medication; or
- Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

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

Covered Service.

Dependent: The 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.

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:

1. Can withstand repeated use
2. Generally is not useful to a person in the absence of illness or injury
3. Is appropriate for use in an individual's home or may be necessary for use at other locations or in the community to allow basic activities of daily living (ADLs) and
4. Primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience

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

Emergency Health Services: Those health care services that must be available on a seven-days-per-week, twenty-four-hours-per-day basis in order to prevent jeopardy to a Member's health status that would occur if such services were not received as soon as possible, and includes, where appropriate, provisions for transportation and indemnity payments or service agreements for out-of-area coverage.

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 Services: means the following:

- A medical screening examination, as required by federal law, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition;
- Such further medical examination and treatment that are required by federal law to Stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

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.

Final Adverse Benefit Determination: An Adverse Benefit Determination that is upheld at the completion of Oscar's internal appeals process.

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 or devices 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, accredited 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 health care practioner licensed, accredited or certified to perform health care services consistent with state law. 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 Ohio 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.

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, a covered Dependent, or a covered individual 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.

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

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.

Placement for Adoption: The assumption and retention by a person of a legal obligation for total or partial support of a Child in anticipation of the adoption of the Child. The Child's placement with a person terminates upon the termination of that legal obligation.

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

Policy: This Policy issued by Oscar Insurance Corporation of Ohio, 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.

SECTION 1: DEFINITIONS

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 Mental Health Disorders or Substance Abuse 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.
- **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 Mental Health Disorders or Substance Abuse 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.

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

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 Ohio, in which We provide coverage.

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.

SECTION 1: DEFINITIONS

Subscriber: The person to whom this Policy is issued. The Subscriber is legally responsible for the payment of Premium and any Co-Payments, Co-Insurance, and Deductible amounts required under this Policy.

Substance Abuse: Alcohol, drug or chemical abuse, overuse, or dependency.

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: Those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may include such health care services provided out of Oscar's approved service area pursuant to indemnity payments or service agreements.

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.

Oscar is not a a member of any guaranty fund, including the Ohio Life and Health Insurance Guaranty Association. In the event of Oscar's insolvency or in the event that Oscar ends operations, You are protected only to the extent that the hold harmless provision required by the Ohio Revised Code section 1751.13 applies to the health care services rendered. This hold harmless provision states that with the exception of an Annual Deductible, Copayment, Coinsurance and non Covered Services, Network Providers may not bill You for Covered Services.

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

In the event of Oscar's insolvency or end of operations, You may have to pay for health care services You receive from a Non-Network Provider, whether or not Oscar authorized the use of the Non-Network Provider. If You need additional information, call Member Services at 1-855-OSCAR-55.

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 Medical 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. You will be responsible for paying the cost of all care that is provided by Non-Network Providers unless We have Preauthorized that care or the Non-Network Provider is administering Emergency or Urgent Care Services (as described in the Emergency and Urgent Care Services section of this Policy).

Network Providers must seek compensation for Covered Services solely from Oscar, except for Copayments and/or Deductibles.

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.

Our Preauthorization is required before You receive certain Covered Services. If Your PCP makes a referral, then the PCP is responsible for the requesting Preauthorization for the Network services listed in the Schedule of Benefits and this Policy that require Preauthorization. However, if You select the Provider, You are responsible for ensuring that Provider is In-Network and requesting the Preauthorization. Preauthorization 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.

G. Preauthorization / Notification Procedure.

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

You or Your Provider must contact Us to request Preauthorization 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 Mental Health Disorder or Substance Abuse treatment admission.
- At least 5 days prior to the start of Home Health Care.
- Before air ambulance services are rendered for a non-Emergency Medical Condition

You or Your Provider must contact Us to provide notification as follows:

- As soon as reasonably possible when air ambulance services are rendered for an Emergency Medical Condition.
- If You are hospitalized in cases of an Emergency Medical Condition, You must call Us within 24 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.

Additional information about Preauthorization can be found in the Utilization Review Section of this document.

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.

Wellness Reward Programs – Oscar may offer voluntary wellness programs that allow you to earn rewards for certain activities. The rewards may include cash, credits, gift cards, premium discounts, modifications to deductibles, copayments or cost-sharing amounts, or other benefits. Information about Oscar wellness programs can be found on the Oscar website by contacting us at 855-OSCAR-55

If you are unable to participate in a wellness program for health reasons, please contact us because you may be able to earn rewards in a different way. If a health condition prevents you from doing a wellness activity, we will work with you find a way that is right for you to earn the same reward. In some cases, we may require a note from your doctor as to how your health status affects your ability to earn a reward. If you have any questions about an Oscar wellness program, activity or reward, please contact us at 855-OSCAR-55.

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
  Monday-Friday, 8:00 a.m.-5:00 p.m.

- MEMBER SERVICES
  855-OSCAR-55
  (Member Services Representatives are available Monday-Friday, 8:00 a.m.-5:00 p.m.)

- 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.

B. Continuity of Care.

We will notify You by mail within thirty (30) days after the termination of a contract with a PCP if You, or a Dependent covered under Your Plan, has received health care services from the terminated PCP within the previous twelve months or if You or Your Dependent has selected the terminated physician as the Your or Your Dependent's PCP within the previous twelve months. We will notify You by mail within thirty (30) days after the termination of a contract with a hospital if You, or a Dependent covered under Your Plan, has received health care services from that hospital within the previous twelve months.

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

In cases where a Network Provider is terminated without cause while a Member is in an Active Course of Treatment with that Provider, the Member may continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.

For all other discontinuations of Provider contracts, We will make a good faith effort to provide written notice of the discontinuation 30 days prior to the effective date

of the change or otherwise as soon as practicable, to You, if You, or a Dependent enrolled under Your plan, are a patient seen on a regular basis by the Provider whose contract is being discontinued.

C. 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 and the cost to You will be no greater than if You received care from a Network Provider . You will be responsible only for any applicable in-network Cost-Sharing. In the event an authorization is not approved, any services rendered by 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 the first to the last day of Your Plan 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. You pay the percentage of the Allowed Amount as shown in the Schedule of Benefits and We will pay the remaining percentage of the Allowed Amount.

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.

"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 Medical Condition and the Access to Care section of this Policy for the Allowed Amount for authorized Non-Network Providers.

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.

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.

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 You 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 lack 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 from the date of Placement for Adoption. Coverage lasts until the end of the year in which the Child turns 26 years of age or Placement for Adoption ends. 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 will not ask for proof of disability more frequently than once per year.

D. Open Enrollment.

You can enroll under this Policy during an open enrollment period that runs from November 1 through December 15 of the prior 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 the date on which We receive notice and payment of any additional required Premiums. If You, Your Spouse or Child enroll because You gain a Dependent through Placement for Adoption, Your coverage will begin on the date of the 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, coverage for Your newborn starts at the moment of birth and continues for 31 days. In order to continue coverage beyond the initial 31 days, You must notify the Exchange within 60 days and pay any additional required Premiums. 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 continue beyond the initial 31 days.

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 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 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 Ohio;
        - 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: MEDICAL PROFESSIONAL SERVICES

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.

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. Rehabilitation Services.

We cover Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy when rendered as physician home visits or as outpatient services. We cover 20 visits per therapy per Plan Year, unless otherwise specified. 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.
- We cover 20 visits per Plan Year for pulmonary rehabilitation, unless pulmonary rehabilitation is rendered as part of physical therapy, in which case the physical therapy visit limits will apply.
- We cover 36 visits per Plan Year for cardiac rehabilitation, which is a program of medical evaluation, education, supervised exercise training, and psychosocial support to restore an individual's functional status after a cardiac event. Home programs, on-going conditioning and maintenance are not covered.

C. Habilitation Services.

We cover health care services or devices 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 and are subject to the visit limits in Your Schedule of Benefits.

For habilitative services for children with Autism Spectrum disorders, we cover speech and language therapy and/or occupational therapy benefits of 20 visits per Plan Year for each service. We also cover 20 hours per week for applied behavioral analysis.

We cover mental or behavioral health outpatient services for an enrollee under the age of fourteen when performed by a licensed psychologist, psychiatrist, or physician providing consultation, assessment, development, or oversight of treatment plans

D. 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.

Coverage for these Diagnostic Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- CAT scans
- Laboratory and pathology services
- Cardiographic, encephalographic, and radioisotope tests
- Nuclear cardiology imaging studies
- Ultrasound services
- Allergy tests
- Electrocardiograms (EKG)
- Electromyograms (EMG) except that surface EMG's are not Covered Services
- Echocardiograms
- Bone density studies
- Positron emission tomography (PET scanning)
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure
- Echographies
- Doppler studies
- Brainstem evoked potentials (BAER)
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)

- Nerve conduction studies
- Muscle testing
- Electrocorticograms
- Central supply (IV tubing) or Pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

E. Maternity and Newborn Care.

We cover services for maternity care provided by a Physician or midwife, advanced practice registered nurse, 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 You are pregnant 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.

F. 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/

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 not subject to Copayments, Deductibles or Coinsurance when provided by a Network Provider.

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.

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.

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.

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.

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.

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.

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.

Smoking Cessation.

We cover a screening for tobacco use and, for those who use tobacco products, tobacco cessation attempts . For this purpose, covering a cessation attempt includes coverage for:

- Tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without Preauthorization; 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 Preauthorization.

SECTION 7: MEDICAL OUTPATIENT 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, ancillary, Facility use, and professional charges when given as an Outpatient at a Hospital, alternative care Facility, retail health clinic, or other Provider as determined by 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. 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.

B. Surgical Services.

We cover Surgical Services when provided as part of a physician home visit, inpatient service, or outpatient service 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.

C. Office Visits.

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

When available in Your area, Your coverage will include online visit services. Covered Services include a medical consultation using the internet via a webcam, chat or voice. See Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. Non Covered Services include, but are not limited to communications used for:

- Reporitng normal lab or other test results
- Office appointment requests
- Billing, insurance coverage or payment questions
- Requests for referrals to doctors outside the online care panel
- Benefit prefertificatoin
- Physician to Physician consultation

D. 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 Manipulation Therapy, which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits 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.

Note: Limits are shown on Your Schedule of Benefits.

Limitations

We cover up to one hundred (100) combined Home Health Care Services visits per Benefit Year. Each visit by an Authorized Representative of a Home Health Care Agency shall be considered as one (1) Home Health Care visit, except that at least four (4) hours of home health aide services shall be considered as one (1) Home Health Care visit. NOTE: The one hundred (100) visit limit maximum for Home Health Care Services does not include private duty nursing rendered in the home. Please see Your Schedule of Benefits for additional terms and limitations.

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.

E. Chemotherapy.

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

F. Clinical Trials.

Benefits are available for services for routine patient care rendered as part of an approved clinical trial if the services are otherwise Covered Services under this Policy. Approved clinical trial means a clinical trial that (1) is a phase I, a phase II, a phase III, or a phase IV clinical trial that is conducted in relation to the prevention of cancer or another life-threatening disease or condition (defined as any disease or condition from which the likelihood of death is probably unless the course of the disease or condition is interrupted); and (ii) 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 or the life-threatening disease;
    - Tests responses to a health care service, item, or drug for the treatment of cancer or the life-threatening disease;
    - Compares the effectiveness of health care services, items, or drugs for the treatment of cancer or the life-threatening disease; or
    - Studies new uses of health care services, items, or drugs for the treatment of cancer or the life-threatening disease;
- 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 Centers for Disease Control and Prevention, or one of its cooperative groups or centers;
    - The Agency for Health Care Research and Quality, or one of its cooperative groups or centers;
    - The Centers for Medicare and Medicaid Services, or one of its cooperative groups or centers;
    - 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 FDA;
- 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.

G. 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.

We cover adult dental x-rays, supplies and appliances and all associated expenses, including hospitalization and anesthesia for transplant preparation, the initiation of immunosuppresives and direct treatment of acute traumatic injury, cancer or cleft palate.

Limitations

Covered Services are limited to $3,000 per Member per accident or occurrence (Network and Non-Network combined). This limit does not apply to outpatient facility charges, anesthesia billed by a Provider other than the Physician performing the service, or to services that We are required by law to cover.

Pediatric

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

H. Dialysis.

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

I. Infertility Treatment.

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

Limitations

Procedures such as IVF, GIFT and ZIFT, which are not essential to the protection of an individual's life, are not covered.

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.

L. 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.

M. 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.

N. 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.

O. 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.

P. 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.

Q. 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.

R. Transplants.

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

- 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 an inpatient service, outpatient services or physician home visit depending where the service is performed subject to Member cost shares.

Covered Transplant Procedure

Any Medically Necessary human organ, cornea, kidney 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.

We cover unrelated donor searches for bone marrow or stem cell transplants up to $30,000 per Covered Transplant Procedure. We also cover the Medically Necessary charges for the procurement of an organ from a live donor, including complications from the donor procedure for up to six weeks from the date of procurement. Donor benefits are limited to benefits not available to the donor from any other source.

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.

Preauthorization

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 $10,000 per transplant.

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 8: MEDICAL HOSPITALIZATION 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.

We do not cover Inpatient Services 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.

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 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 or advanced practice registered nurse 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 or advanced practice registered nurse 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 or a source of follow-up care directed by an advanced practice registered nurse 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. Rehabilitation Services.

We cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy. Inpatient Rehabilitation Services and Day Rehabilitation Program services are limited to a combined maximum of 60 days per Plan Year.

Day Rehabilitation Program services provided through a Day Hospital for Rehabilitation Services are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two therapy services must be provided for this program to be a Covered Service.

G. 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.

H. Limitations/Terms of Coverage.

1. When You are receiving inpatient care in a Facility, We will not cover additional charges for medications and supplies You take home from the Facility.
2. We will cover additional charges for special duty nurses and charges for private rooms if Medically Necessary. 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.
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 9: EMERGENCY HEALTH 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. Emergency Care (including Emergency Room Services)

We cover Emergency Services for the treatment of an Emergency Medical Condition in a Hospital. For example, an Emergency Medical 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 Medical Condition will be provided regardless of whether the Provider is a Network Provider. We will also cover Emergency Services to treat Your Emergency Medical 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 Medical Condition in a Hospital.

We do not cover care received in an emergency room that is not treating an Emergency Medical Condition, except as specified in this Policy. This includes, but is not limited to suture removal in an emergency room.

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

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Medical 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 Medical 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.

   You are only responsible for any Network Copayment, Deductible or Coinsurance. You are not responsible for any Non-Network Provider charges that exceed Your Copayment, Deductible or Coinsurance. If You receive a Balance Billing charge from a Non-Network Emergency Provider for anything other than a Copayment, Deductible or Coinsurance, please contact Oscar at 855-OSCAR-55.

B. Urgent Care

Often an urgent rather than an Emergency Medical Condition exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services are covered when received from a Network Provider. Urgent Care Services received from a Non-Network Provider are not covered. If You experience an accidental injury or a medical problem, We will determine whether Your injury or condition requires Urgent Care or Emergency Services for coverage purposes, based on Your symptoms.

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 Medical Condition. 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 10: AMBULANCE 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 Medical Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

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

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Medical 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

- Ambulance services are covered only when Medically Necessary, except:
    - When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse; or
    - When a Member is required by Us to move from a Non-Network Provider to a Network Provider.
- We do not cover travel or transportation expenses, unless connected to an Emergency Medical 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;
    - Trips to a Physician's office or clinic; or
    - Trips to a morgue or funeral home.
- Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for Your condition. If none of these facilities are in Your local area, You are covered for trips to the closest facility outside Your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service.

SECTION 11: PRESCRIPTION DRUG COVERAGE

Please refer to the Schedule of Benefits for Cost-Sharing requirements, supply 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.

Covered 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.
- 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.

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

The non covered Prescription Drug benefits above may be covered if approved during the Formulary Exception Process.

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 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 contracted rate of the Prescription Drug on the higher tier and the contracted rate 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. 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, including contraceptives, 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 approved, the costs will count toward the Out-of-Pocket Maximum. 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.

For contraceptives only, We will defer to Your Provider's recommendation of Medical Necessity and will provide the contraceptive service or FDA approved item without cost sharing upon request.

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. If You owe a Copayment, You are responsible for one (1) Copayment amount for a 30-day supply up to a maximum of two and a half (2.5) Copayment amounts for a 90-day supply. The Coinsurance amount listed on Your Schedule of Benefits applies no matter the supply amount.

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 Medical 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. The Coinsurance amount listed on Your Schedule of Benefits applies no matter the supply amount.

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.

F. Opioid Analgesics Prescriptions for Chronic Pain Treatment.

The Preauthorization requirements and utilization review measures described in this section are required as conditions of providing coverage of an opioid analgesic prescribed for the treatment of chronic pain, unless the drug is prescribed under one of the following circumstances:

- To an individual who is a hospice patient in a hospice care program;
- To an individual who has been diagnosed with a Terminal Condition but is not a hospice patient in a hospice care program; or
- To an individual who has cancer or another condition associated with the individual's cancer or history of cancer.

SECTION 11: PRESCRIPTION DRUG COVERAGE

In determining whether the Preauthorization and utilization review measures may be waived, We will consider either or both of the following, as applicable to the case in which the opioid analgesic is prescribed:

- If the course of treatment with the drug continues for more than ninety (90) days, the requirements of section 4731.052 of the Ohio Revised Code;
- If the morphine equivalent daily dose for the drug exceeds eighty (80) milligrams or the individual is being treated with a benzodiazepine at the time the opioid analgesic is prescribed, the guidelines established by the governor's cabinet opiate action team and presented in the document titled "Ohio Guidelines for Prescribing Opioids for the Treatment of Chronic, Non-terminal Pain 80 m g of a Morphine Equivalent Daily Dose (MED) 'Trigger Point'" or a successor document, unless the guidelines are no longer in effect at the time the opioid analgesic is prescribed.

As used in this section, "Terminal Condition" means an irreversible, incurable, and untreatable condition that is caused by disease, illness, or injury and will likely result in death. A Terminal Condition is one in which there can be no recovery, although there may be periods of remission.

Medication synchronization is a pharmacy service that synchronizes the filling or refilling of prescriptions in a manner that allows the dispensed drugs to be obtained on the same date each month. We will provide medication synchronization if all the following conditions are met:

1. You elect to participate in medication synchronization;
2. You, Your Provider, and a pharmacist at a network pharmacy agree that medication synchronization is best for You; and
3. All the following requirements are met:
    a. The drug is covered and not excluded;
    b. The drug is prescribed for a chronic disease or condition and is subject to refills;
    c. You have satisfied all Preauthorization requirements;
    d. The drug does not have quantity limits, dose optimization criteria, or other requirements that would be violated if synchronized;
    e. The drug does not have special handling or sourcing needs that require a single, designated pharmacy to fill or refill the prescription;
    f. The drug is formulated so that the quantity or amount dispensed can be effectively divided in order to achieve synchronization;
    g. The drug is not a schedule II controlled substance, opiate, or benzodiazepine. For each drug subject to medication synchronization,

we will authorize coverage when the drug is dispensed in a quantity or amount that is less than a thirty-day supply on a one time basis, except if the prescribed dosage or frequency of administration changes or the drug changes. We will also apply a prorated daily cost-sharing rate for a supply of a synchronized medications dispensed at a network pharmacy.

SECTION 12: MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Coverage for Mental Health and Substance Use Disorder Services also includes coverage for 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 and any Preauthorization or Referral requirements that apply to these benefits.

Mental Health Disorders and Substance Abuse treatment is covered like other medical and surgical coverage under this Policy. This Plan is compliant with the Mental Health Parity and Addiction Equity Act.

SECTION 13: ADDITIONAL SERVICES, 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. An assistive communication device is Durable Medical Equipment (DME). We cover the rental (or, at Our option, the purchase) of assistive communication devices when 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 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. See the "Durable Medical Equipment and Braces" section for additional detail on Our coverage of DME.

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 Ohio 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 Ohio 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 the Ohio 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 Ohio 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.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes.

1. Equipment and Supplies.

SECTION 13: ADDITIONAL SERVICES, EQUIPMENT AND DEVICES

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 Ohio law designates as appropriate for the treatment of diabetes.

Diabetic equipment and supplies are covered only when obtained from a Network Provider or 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. 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.

D. 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.

Limitations

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.

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.

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 13: ADDITIONAL SERVICES, EQUIPMENT AND DEVICES

SECTION 14: 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.

G. 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.

H. 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.

I. 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;
- Sealants on unrestored permanent molar teeth (1 sealant per tooth every 36 months);
- Fixed or removable, unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth; and
- Re-cementation or re-bonding of space maintainers.

J. Routine Dental Care.

We cover routine dental care provided in the office of a dentist. Covered Services range from fillings to specific types of crowns. The list below is an example and not wholly inclusive of all Covered Services.

- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt), including:
    - Periodic oral evaluation
    - Limited oral evaluation
    - Comprehensive oral evaluation
    - Comprehensive periodontal evaluation;
- Palliative treatment of dental pain – minor procedure;
- Intraoral complete set of images, including bitewings – limited to one every 60 months;

- Intraoral periapical (first film), periapical (each additional film), occlusal film;
- Bitewing single film, two films or four films (1 set every 6 months);
- Vertical bitewings – 7 to 8 films (1 set every 6 months);
- Panoramic film (1 film every 60 months);
- Cephalometric x-rays;
- Oral/Facial Photographic Images;
- Diagnostic models;
- Amalgam, primary or permanent;
- Resin-based composite(s), anterior;
- Re-cement inlay or crown;
- Prefabricated stainless steel crown, primary or permanent tooth (1 per tooth in 60 months);
- Protective restoration;
- Pin retention per tooth, in addition to restoration;
- Endodontic Services, including:
    - Therapeutic pulpotomy (excluding final restoration);
    - Partial pulpotomy for apexogenesis;
    - Pulpal therapy (resorbable filling);
- Periodontal Services, including:
    - Periodontal scaling and root planning;
    - Periodontal maintenance;
- Prosthodontic Services, including:
    - Adjust complete denture;
    - Adjust partial denture;
    - Repair broken complete denture base, missing or broken teeth (complete denture), resin denture base, or case framework;
    - Repair or replace broken clasp;
    - Add tooth or clasp to existing partial denture;
    - Rebase or reline complete maxillary denture, maxillary partial denture, mandibular partial denture (1 in a 36-month period 6 months after the initial installation);
    - Tissue conditioning;
- Oral Surgery, including:
    - Extration, erupted toth or exposed root;
    - Removal of impacted tooth;
    - Surgical removal of residual tooth roots;
    - Coronectomy;
    - Tooth reimplantation or stabilization of accidentally evulsed or displaced tooth;

  - Surgical access of an unerupted tooth;
  - Alveoloplasty in and not in conjunction with extractions;
  - Removal of exostosis;
  - Incision and drainage of absess;
  - Suture of recent small wounds up to 5 centimeters;
  - Excision of pericoronal gingiva; and
- Other restorative materials appropriate for children.

K. Major Dental.

Covered Services include root canals , oral surgery, dentures, bridges endodontic services and periodontal therapy. The list below is an example and not wholly inclusive of all Covered Services.

- Detailed and extensive oral evaluation, problem focused;
- Inlay and onlay, metallic;
- Crowns – porcelain/ceramic substrate, porcelain fused to high noble metal, porcelain fused to predominately base metal, porcelain fused to noble, ¾ cast high noble metal, ¾ cast predominately base metal, ¾ porcelain/ceramic, full cast high noble metal, full cast predominately base metal, full cast noble metal, titanium (1 per tooth every 60 months);
- Prefabricated post and core, in addition to crown;
- Crown repair, by report;
- Endodontic Services, including:
  - Anterior, bicuspid or molar root canal;
  - Retreatment of previous anterior, bicuspid or molar root canal;
  - Apexification/recalcification initial visit, interim medication replacement and final visit;
  - Pulpal regeneration;
  - Apicoectomy/periradicular surgery;
  - Root amputation;
  - Hemisection;
- Periodontal Services, including:
  - Gingivectomy or gingivoplasty;
  - Gingival flap procedure;
  - Clinical crown lengthening;
  - Osseous surgery;
  - Pedicle and free soft tissue graft procedure;
  - Subepithelial connective tissue graft procedures;
  - Full mouth debridement to enable comprehensive evaluation and diagnosis (1 per lifetime);

- Prosthodontic Services, including:
  - Complete or immediate denture, maxillary or mandibular (1 every 60 months);
  - Maxillary or Mandibular partial denture, resin based or cast metal framework with resin denture base (1 every 60 months);
  - Removable unilateral partial denture, one piece cast metal (1 every 60 months);
  - Implant and abutment;
  - Pontic;
  - Inlay or onlay services; and
  - Crown.

L. 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:

- Limited orthodontic treatment of the primary dentition, the transitional dentition, or the adolescent dentition;
- Interceptive orthodontic treatment of the primary dentition or the transitional dentition;
- Comprehensive orthodontic treatment of the transitional dentition or the adolescent dentition;
- Removable appliance therapy;
- Fixed appliance therapy;
- Pre-orthodontic treatment visit;
- Periodic orthodontic treatment visit (as part of contract); and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

Limitations/Exclustions:

We do not provide coverage:

- Health care services not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, We will pay for eligible Covered Services provided by an authorized dental hygienist

performing within the scope of his or her license and applicable state law;
- Health care services which are Experimental or Investigational Services;
- Health care services which are for any sickness or Injury which occurs in the course of employment if a benefit is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not You claim the Benefits;
- Health care services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;
- Health care services performed prior to Your effective date of coverage;
- Health care services incurred after the termination date of Your coverage unless otherwise indicated;
- Health care services which are not Medically Necessary or which do not meet generally accepted standards of dental practice;
- Health care services resulting from Your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any health care services that are considered strictly cosmetic procedures including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Health care services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction, except as otherwise stated in this Policy;
- Health care services provided as a result of intentionally self-inflicted injury or sickness;
- Health care services provided or charges billed as a result of injuries, conditions, or disabilities suffered while or as a result of committing or attempting to commit a criminal act;
- Health care services provided or charges billed as a result of injuries, conditions, or disabilities suffer while or as a result of engaging in an illegal occupation;
- Health care services provided or charges billed as a result of injuries, conditions, or disabilities suffered while or as a result of participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of Your records, charts or x-rays, or any costs associated with forwarding/mailing copies of Your records, charts or x-rays;
- State or territorial taxes on dental health care services performed;

- Health care services submitted by a dentist, which are for the same health care services performed on the same date for the same Member by another dentist;
- Health care services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- Those for which the Member would have no obligation to pay in the absence of the benefits provided under this Policy;
- Health care services which are for specialized procedures and techniques;
- Health care services performed by a dentist who is compensated by a Facility for similar Covered Services performed for Members;
- Duplicate, provisional and temporary devices, appliances, and health care services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;
- Health care services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Gold foil restorations;
- Health care services for injuries resulting from the maintenance or use of a motor vehicle if such health care services is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
- Health care services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- Hospital costs or any additional fees that the dentist or Hospital charges for health care services at the Hospital (Inpatient or Outpatient);
- Charges by the Provider for completing dental forms;
- Adjustment of a denture or bridgework which is made within six (6) months after installation by the same dentist who installed it;
- Use of material or home health aides to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Cone beam imaging and cone beam MRI procedures;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Orthodontic care for Dependent children age nineteen (19) and over;
- Fabrication of athletic mouth guard;
- Internal and external bleaching;

- Topical medicament center;
- Bone grafts when done in connection with extractions, apicoetomies or non Covered Services;
- When two or more health care services are submitted and the health care services are considered part of the same health care service to one another. We will pay the most comprehensive health care services (the service that includes the other nonbenefited service) as determined by Us;
- When two or more health care services are submitted on the same day and the health care services are considered mutually exclusive (when one service contradicts the need for the other service). We will pay for the service that represents the final health care services as determined by Us;
- All health care services rendered by a non Network Provider, unless specifically authorized by Us. The Member may be responsible for all remaining charges that exceed the allowable maximum.
- 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, unless Medically Necessary.
- For Dental braces, unless Medically Necessary.
- 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:
    - initiation of immunosuppresives.
    - direct treatment of acute traumatic injury, cancer or cleft palate.

SECTION 15: 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.

Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses. Polycarbonate lenses are covered in full for children,

monocular patients and patients with prescriptions > +/- 6.00 diopters. All lenses include scratch resistant coating with no additional copayment.

We also cover the following Optical Lenses and Treatments:

- Ultraviolet Protective Coating
- Polycarbonate Lenses (if not child, monocular or prescription >+/-6.00 diopters)
- Blended Segment Lenses
- Intermediate Vision Lenses
- Standard Progressives
- Premium Progressives (Varilux®, etc.)
- Photochromic Glass Lenses
- Plastic Photosensitive Lenses (Transitions®)
- Polarized Lenses
- Standard Anti-Reflective (AR) Coating
- Premium AR Coating
- Ultra AR Coating
- Hi-Index Lenses

D. Low Vision.

Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for Our Members with low vision. Network Providers will obtain the necessary Preauthorization for these Covered Services. Covered Services for low vision will include one comprehensive low vision evaluation every five (5) years.

E. Limitations and Exclusions.

We do not provide coverage 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.
- 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.
- Vision orthoptic training.
- Services provided by Non-Network Providers.
- Office infection control charges.

- Medical treatment of eye disease or injury.
- Visual therapy.
- Special lens designs or coatings other than those described above.
- Replacement of lost or stolen eyewear.
- Non-prescription (Plano) lenses.
- Two pairs of eyeglasses in lieu of bifocals.
- Prosthetic devices and services.
- Insurance of contact lenses.

SECTION 16: EXCLUSIONS

Basic Health Care Services will not be excluded because they were the result of a complication from a non-Covered Service. No coverage is available under this Policy for those procedures, 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 court ordered testing or care unless Medically Necessary.
- For which You have no legal obligation to pay in the absence of this or like coverage.
- 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.
    - 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. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if they had enrolled.
- Charges in excess of Our Maximum Allowable Amounts.
- 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. This exclusion does not apply to conditions during the cosmetic procedure or in the immediate post-operative timeframe, 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.
    - 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.
- 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.
- For marital counseling.
- 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, except as required by law, authorized by Us, or as otherwise described in this Policy.
- 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 Manipulation Therapy services rendered in the home as part of Home Care Services.
- Surgeries related to 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 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 Preauthorization.
- 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.
- For room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission for Your condition.
- For the reversal of voluntarily induced surgical sterilization.
- For adult 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 adult 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 adult Dental implants.
- For adult Dental braces.
- For adult 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:
    - initiation of immunosuppresives.
    - direct treatment of acute traumatic injury, cancer or cleft palate.
- For Hearing Aids
- For Acupuncture
- For customization of vehicles.

- For vehicle lifts for wheelchairs and/or scooters.
- For modifications to the Member's home.
- For hypnotherapy.
- For coma stimulation.
- For compulsive gambling treatment.
- For any federal, state, or local taxes due on benefits, goods, or services.
- For any shipping and handling charges.
- For any services required while a Member is incarcerated.

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.

SECTION 16: EXCLUSIONS

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.

SECTION 16: EXCLUSIONS

We have the sole 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 receive care through a Network Provider, You are not required to file a claim. This means that the provisions below, regarding Claim Forms and Notice of Claim, do not apply unless the Provider did not file the claim.

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.

Note: Under Ohio law, You have the right to obtain an itemized copy of Your billed charges from the Hospital or Facility which provided services.

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. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

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 and effectively provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

A. Preauthorization.

Network Providers are required to obtain Preauthorization in order for You to receive benefits for certain services. Preauthorization 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. If We authorize a proposed admission, treatment, or health care service by a Network Provider based upon the complete and accurate submission of all necessary information relative to a Member, We will not retroactively deny this authorization if the Network Provider renders the service in good faith and pursuant to the authorization and all of the terms and conditions of the Network Provider's contract with Us.

Preauthorization 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 Mental Health Disorder or Substance Abuse treatment admission.
- At least 5 days prior to the start of Home Health Care.

Preauthorization for Members with Chronic Conditions

For purposes of this section, "chronic condition" means a medical condition that has persisted after reasonable efforts have been made to relieve or cure its cause and has continued, either continuously or episodically, for longer than six continuous months. For Preauthorizations approvals related a Member's chronic condition, We will honor the Preauthorization for an approved Prescription Drug for twelve (12) months or until the last day of the Member's eligibility under this Policy, whichever is less. The twelve (12) month approval provided by Us will no longer be valid and will automatically terminate if there are changes to federal or state laws or federal regulatory guidance or compliance information prescribing that the Prescription Drug in question is no longer approved or safe for the intended purpose.

We may require a Member's Provider to submit information to Us indicating that a Member's chronic condition has not changed. The frequency of the submission of requested information by Us will be consistent medical or scientific evidence as defined in Ohio Revised Code 3922.01, but will not be required more frequently than on a quarterly basis. If We request information from a Member's Provider and the Provider does not respond to Us within five (5) calendar days from the date the request was received by the Provider, We may terminate the twelve (12) month approval.

We will not authorize a twelve (12) month approval for the following:

- Prescription Drugs that are prescribed for a non-maintenance condition;
- Prescription Drugs that have a typical treatment of less than one (1) year;
- Prescription Drugs that require an initial trial period to determine effectiveness and tolerability, beyond which a one (1) year or greater Preauthorization period will be given;
- Prescription Drugs where the medical or scientific evidence, as defined in Ohio Revised Code 3922.01, does not support a twelve (12) month prior approval;
- Prescription Drugs that are a Schedule I or II controlled substance or any opioid analgesic or benzodiazepine, as defined in Ohio Revised Code 3719.01; or
- Prescription Drugs that are not prescribed by a Network Provider as part of a care management program.

Note: If We have provided a twelve (12) month approval for a Prescription Drug and the FDA subsequently releases an approved comparable brand or generic

Prescription Drug that is listed as therapeutically equivalent in FDA's publication titled "Approved Drug Products with Therapeutic Equivalence Evaluations," then We may require a substitution and require the therapeutically equivalent Prescription Drug be used for the remainder of the twelve (12) month approval.

Electronic Preauthorization Requests

Once We receive Your Preauthorization request through a secure online portal, We will respond within 48 hours for urgent care services, or 10 calendar days for any other Preauthorization requests. If Your request is incomplete, We will indicate the specific additional information that is required to process the request. For purposes of this section, "urgent care services" means a medical care or other service for a condition where application of the timeframe for making routine or non-life-threatening care determinations is either of following:

- Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;
- In the opinion of the Provider with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without care or treatment that is the subject of the request.

Retrospective Review of Claim

Upon written request, We may permit a retrospective review for a claim that is submitted for a service where Preauthorization is required but not obtained if the service in question meets all of the following:

- The service is directly related to another service for which prior approval has already been obtained and that has already been performed.
- The new service was not known to be needed at the time the original Preauthorized service was performed.
- The need for the new service was revealed at the time the original authorized service was performed.

Once the written request and all necessary information is received, We will review the claim for coverage and medical necessity. We will not deny a claim for such a new service based solely on the fact that a Preauthorization approval was not received for the new service in question. Note: Retrospective review of a claim is available for all applicable Preauthorization requests and is not limited to electronic preauthorization requests.

Adverse Preauthorization Appeals Timeframes

For urgent care services, We will consider an adverse Preauthorization appeal

within 48 hours after We receive the appeal. For all other preservice requests, We will consider the appeal within 10 calendar days after We receive the appeal. For post-service requests, We will consider the appeal within 30 calendar days. The appeal is between the Provider requesting the service in question and a clinical peer.

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	24 hours or 1 business day from the

received less than 24 hours before the expiration of the previous authorization or no previous authorization exists)	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.

Reconsideration of an Adverse Determination

For Adverse Benefit Determinations related to concurrent requests or prospective requests, Your Provider or Facility rendering the health care service may request – in writing on Your behalf – a reconsideration of the Adverse Benefit Determination by conducting a peer-to-peer review. The Provider or Facility may not request reconsideration without Your prior consent. The reconsideration shall occur within three (3) business days after We receive the written request for reconsideration, and shall be conducted between the Provider or Facility rendering the health care service and the reviewer who made the Adverse Benefit Determination.

The reconsideration must be conducted between the Provider rending the health care service and the reviewer who made the Adverse Benefit Determination; provided however, that if Our reviewer is not available, such reviewer may

designate another reviewer. Your Provider must have Your written consent in order to conduct this peer-to-peer review with Our reviewer or Our designee.

We will reconsider the Adverse Benefit Determination within three (3) business days after We receive the request for reconsideration. For requests for reconsideration related to an urgent care service Request, We will review such request in a timeframe that takes into account the medical exigencies. Reconsideration is not a prerequisite to an Internal or External Review of an Adverse Benefit Determination.

SECTION 19: COMPLAINTS, APPEALS AND EXTERNAL REVIEW

Complaint and Appeal procedures have been established to provide fair, reasonable, and timely solutions to complaints that You may have concerning the Plan. We invite You to share any concerns that You may have over benefit determinations, coverage and eligibility issues, or the quality of care rendered by medical Providers in Our Networks.

A. The Complaint 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 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 Appeal Procedures.

As a Member of this Plan You have the right to appeal decisions to deny or limit Your health care benefits. The explanation of why We denied Your claim or request for benefits will describe the steps You should follow to initiate Your appeal and how the appeal process works.

An appeal is a request from You for Us to change a previous determination or to address a concern You have regarding confidentiality or privacy.

C. Internal Appeals.

An initial determination by Us can be appealed for internal review. We offer only one level of internal appeal. The Plan will advise You of Your rights to appeal to the next level if a denial occurs after an initial determination.

You have the right to designate a representative (e.g. Your Physician) to file appeals with Us on Your behalf and to represent You in any level of the appeals process. If a representative is seeking an appeal on Your behalf, We must obtain a signed Designation of Representation (DOR) form from You. The appeal process will not

begin until We have received the properly completed DOR form except that if a Physician requests expedited review of an appeal on Your behalf, the Physician will be deemed to be Your designee for the limited purpose of filing for expedited review of the appeal without receipt of a signed form. We will forward a DOR form to You for completion in all other situations.

We will accept oral or written comments, documents or other information relating to an appeal from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal. To obtain information on Our appeal procedures or to file an oral appeal please call the toll free customer service number Your ID Card or the number provided for appeals on any written notice of an adverse decision that You receive from Us.

We will also accept appeals filed in writing. If You wish to file Your appeal in writing, You must mail it to: Oscar, PO Box 52146, Phoenix, AZ 85072-2146, or to the address provided for filing an appeal on any written notice of an adverse decision that You receive from Us.

Upon Our receipt of Your written or oral appeal at the appeals address or telephone number provided above or provided on any notice of an adverse decision, We will send You an acknowledgment within 5 business days notifying You that You will receive a written response to the appeal once an investigation into the matter is complete. Our acknowledgment may be oral for those appeals We receive orally.

D. Appeals.

Appeals are reviewed by persons who did not make the initial determination and who are not the subordinates of the initial reviewer. If a clinical issue is involved, We will use a clinical peer for this review. A clinical peer is a Physician or Provider who has the same license as the Provider who will perform or has performed the service. The clinical peer will review Your medical records and determine if the service is covered by Your benefit document. If the clinical peer determines that the service is covered by Your benefit document We must pay for the service; if the clinical peer determines that the service is not covered We may deny the services.

If You are appealing an adverse precertification decision other than a retrospective post-claim review decision (i.e., an adverse prospective, concurrent or retrospective

pre-claim review decision) or the denial of any prior approval required by the Plan, We will provide You with a written response indicating Our decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days of the date We receive Your appeal request. If more information is needed to make a decision on Your Appeal, We will send a written request for the information after receipt of the Appeal. No extensions of time for additional information may be taken on these Appeals without the permission of the Member. Therefore, We will make a decision based upon the available information if the additional information requested is not received.

If You are appealing any other type of adverse decision (including retrospective post-claim review decisions) and sufficient information is available to decide the Appeal, We will provide You with a written response indicating Our decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days from receipt of the Appeal request. If more information is needed to make a decision on Your Appeal, We shall send a written request for the information after receipt of the Appeal. If the additional information requested is not received within 45 calendar days of the Appeal request, We shall conduct its review based upon the available information.

E. Expedited Reviews.

Expedited Review of an appeal may be initiated orally, in writing, or by other reasonable means available to You or Your Provider. Expedited Review is available only if the medical care for which coverage is being denied has not yet been rendered. If You submit the internal appeal electronically, Oscar will consider the appeal within 48 hours after Our receipt of the request and will communicate Our decision by telephone to Your attending Physician or the ordering Provider. We will also provide written notice of Our determination to You, Your attending Physician or ordering Provider, and the facility rendering the service. If You do not submit the internal appeal electronically, We will consider the appeal within 72 hours after receipt of the request.

You may request an expedited review for:

- Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
    - 1. Could seriously jeopardize Your life or health or Your ability to regain maximum function, or,
    - 2. In the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately

managed without the care or treatment that is the subject of the claim.

- Except as provided below, a claim involving urgent care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- Any claim that a Physician with knowledge of Your medical condition determines is a claim involving urgent care. We shall defer to such determination of the attending Provider.

F. Exhaustion of Internal Appeals Process.

The internal appeal process must be exhausted prior to initiating an external review except in the following instances:

- We agree to waive the exhaustion requirement; or
- You did not receive a written decision of Our internal appeal within the required time frame; or
- We failed to meet all requirements of the internal appeal process unless the failure:
  - Was de minimis (minor);
  - Does not cause or is not likely to cause prejudice or harm to You;
  - Was for good cause and beyond Our control;
  - Is not reflective of a pattern or practice of non-compliance; or
- An expedited external review is sought simultaneously with an expedited internal review.

G. External Review.

Under Chapter 3922 of the Ohio Revised Code all health plan issuers must provide a process that allows a person covered under a health benefit plan or a person applying for health benefit plan coverage to request an independent external review of an Adverse Benefit Determination. This is a summary of that external review process. An Adverse Benefit Determination is a decision by Us to deny benefits because services are not covered, are excluded, or limited under the plan, or the covered person is not eligible to receive the benefit.

The Adverse Benefit Determination may involve an issue of medical necessity, appropriateness, health care setting, or level of care or effectiveness. An Adverse Benefit Determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. We will provide You the opportunity for an external review by an IRO for an Adverse Benefit Determination if the determination involved a medical judgment. We will provide you the opportunities for an external review by the Ohio Department of insurance for issues that do not involve medical judgment (for example, Adverse Benefit Determinations based on contractual issues or for an Adverse Benefit Determination in which emergency medical services have been determined to be not medically necessary or appropriate after an external review by an IRO. The covered person does not pay for the external review. There is no minimum cost of health care services denied in order to qualify for an external review. However, the covered person must generally exhaust the health plan issuer's internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the Adverse Benefit Determination.

External Review by an IRO

A covered person is entitled to an external review by an IRO in the following instances:

- The Adverse Benefit Determination involves a medical judgment or is based on any medical information.
- The Adverse Benefit Determination
- indicates the requested service is Experimental or Investigational, the requested service is not explicitly excluded in Your Plan, and the treating Physician certifies at least one of the following:
    - Standard health care services have not been effective in improving Your condition.
    - Standard health care services are not medically appropriate for You.
    - No available standard health care service covered by Us is more beneficial than the requested health care service.

Request for External Review

Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the covered person, or an Authorized Representative, must request an external review through Us within 180 days of the date of the notice of Final Adverse Benefit Determination issued by Us. All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally; however written confirmation of the request must be submitted to Us no later than five (5) days after the initial request. The covered person will be required to consent to the release of applicable

medical records and sign a medical records release authorization.

If the request is complete We will initiate the external review and notify the covered person in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the covered person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. We will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

A covered person may make a request for an expedited external review:

- After an Adverse Benefit Determination, if both of the following apply:
    - The covered person's treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the covered person, or would jeopardize the covered person's ability to regain maximum function, if treated after the time frame of an expedited internal appeal; and
    - The covered person has filed a request for an expedited internal appeal.
- After a Final Adverse Benefit Determination, if either of the following apply:
    - The covered person's treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the covered person, or would jeopardize the covered person's ability to regain maximum function, if treated after the time frame of a standard external review; or
    - The Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not yet been discharged from a facility.

A covered person may request orally or by electronic means an expedited review under this section if the person's treating physician certifies that the requested health care service in question would be significantly less effective if not promptly initiated. Immediately upon receipt of a request for an expedited external review, We will determine if the request is complete and eligible for expedited external

review. We will immediately notify the covered person of Our determination.

If the request is not complete We will inform the covered person in writing and specify what information is needed to make the request complete. If We determine that the Adverse Benefit Determination is not eligible for external review, We must notify the covered person in writing and provide the covered person with the reason for the denial and inform the covered person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by Us and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the health benefit plan and all applicable provisions of the law.

IRO Assignment

When We initiate an external review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of health care service. An IRO that has a conflict of interest with Us, the covered person, the health care provider or the health care facility will not be selected to conduct the review.

IRO Review and Decision

The IRO must consider all documents and information considered by Us in making the Adverse Benefit Determination, any information submitted by the covered person and other information such as; the covered person's medical records, the attending Health Care Professional's recommendation, consulting reports from appropriate Health Care Professionals, the terms of coverage under the health benefit plan, the most appropriate practice guidelines, clinical review criteria used by the health plan issuer or its utilization review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by Us of a request for a standard review or within 72 hours of receipt by Us of a request for an expedited review. This notice will be sent to the covered person, Us and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review.
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
- The dates over which the external review was conducted.

- The date on which the independent review organization's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision.

NOTE: Written decisions of an IRO concerning an Adverse Benefit Determination that involves a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

Binding Nature of External Review Decision

An external review decision is binding on Us except to the extent We have other remedies available under state law. The decision is also binding on the covered person except to the extent the covered person has other remedies available under applicable state or federal law. A covered person may not file a subsequent request for an external review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to Us.

If You Have Questions About Your Rights or Need Assistance You may contact Us:

- By Mail: Oscar, PO Box 52146 Phoenix, AZ 85072-2146
- By Phone: 1-855-OSCAR-55

You may also contact the Ohio Department of Insurance:

- By Mail: Ohio Department of Insurance, ATTN: Consumer Affairs, 50 West Town Street, Suite 300, Columbus, OH 43215
- By Phone: 800-686-1526 / 614-644-2673; 614-644-3745 (TDD)
- By Fax: 614-644-3744
- Web: https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp
- File a Consumer Complaint: http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

Appeal Filing Time Limit

We expect that You will use good faith to file an appeal on a timely basis. However, We will not review an appeal if it is received by Us after 180 days have passed since the incident leading to Your appeal.

SECTION 20: TERMINATION AND RENEWABILITY OF COVERAGE

You may renew this Policy at Your option without regard to Your health condition. 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 year in which the Child turns 26 years of age.
3. For all other Dependents, the end of the year 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 31 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 31-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 or is no longer eligible for coverage through the Exchange.

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.

6. The date the Enrollee changes from one plan to another through open or special enrollment.

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 five () Policies offered by Us.

SECTION 23: COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

A. Definitions.

A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- (1) Plan includes: group and nongroup insurance contracts, health insuring corporation (HIC) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
- (2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB

provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The **order of benefit determination rules** determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

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

Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are **not** Allowable expenses:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
- If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
- If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
- If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the

Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

- The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

B. Order of Benefit Determination Rules.

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- (A) The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- (B) (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

  (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- (C) A Plan may consider the benefits paid or provided by another Plan in

calculating payment of its benefits only when it is secondary to that other Plan.

- (D) Each Plan determines its order of benefits using the first of the following rules that apply:
    - (1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
    - (2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
        - (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
            - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
            - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
            - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
        - (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
            - (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
            - (ii) If a court decree states that both parents are responsible for the dependent child's health care

expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

- (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
- If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    - The Plan covering the Custodial parent;
    - The Plan covering the spouse of the Custodial parent;
    - The Plan covering the non-custodial parent; and then
    - The Plan covering the spouse of the non-custodial parent.

- (c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

- (3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee,

member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

- (5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
- (6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

C. Effect on the Benefits of this Plan.

When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

D. Right to Receive and Release Needed Information.

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. The Organization that helps us administer COB, The Rawlings Company LLC,, may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. Rawlings need not tell, or

get the consent of, any person to do this. Each person claiming benefits under This plan must give Rawlings any facts it needs to apply those rules and determine benefits payable.

E. Facility of Payment.

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

F. Right of Recovery.

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

G. Coordination Disputes.

If You believe that we have not paid a claim properly, You should first attempt to resolve the problem by contacting us at 1-855-OSCAR-55 or by email at oscarmanualreferrals@rawlingscompany.com. If You are still not satisfied, You may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at http://insurance.ohio.gov.

SECTION 24: 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 cannot assign any benefits under this Policy to any person, corporation or other organization without obtaining written permission from the Plan. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Policy or Your right to collect money from Us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.

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 Ohio.

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 Ohio State law or with any applicable federal law that imposes additional requirements from what is required under Ohio 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. In other words, benefit limitations will reset upon Plan renewal, not after a mid-year change in coverage status.

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.

We will review all other third-party payments, including payments made by private, not-for-profit foundations, on a case-by-case basis. We may decline to accept third-party payments, including payments by third-party individuals, that raise concerns for potential conflicts of interest, adverse selection, or fraud. In its review, We will take into consideration factors, including whether eligibility was based solely on the enrollee's financial status, without consideration of the enrollee's health status, and if assistance is provided for the entire policy year. We will closely review, and reserve the right to decline, all third-party payments from provider-affiliated organizations (including nonprofit organizations affiliated with providers), with which the Federal Department of Health and Human Services has identified various concerns, including the potential for future financial harm to consumers.

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.
On occasion, a payment will be made to You when You are not covered, for a

service that is not covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

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 claim 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 claims 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.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if You or anyone on Your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. When entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and Us. It is presumed that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

However, notwithstanding the above, Our rights or any other person or entity that asserts a contractual, statutory, or common law subrogation claim against a third party or You in a Tort Action will be subject to the following conditions:

- If less than the full value of the Tort Action is recovered for comparative negligence, diminishment due to a party’s liability under sections 2307.22 to

2307.28 of the Ohio Revised Code, or by reason of the collectability of the full value of the claim for Injury, death, or loss to person resulting from limited liability insurance or any other cause, the Plan's or other person's or entity's claim shall be diminished in the same proportion as Your interest is diminished.

- If a dispute regarding the distribution of the recovery in the Tort Action arises, either the Plan or You may file an action under Chapter 2721 of the Ohio Revised Code to resolve the issue of the distribution of the recovery.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of 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 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 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 Ohio. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to Ohio 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.

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 Ohio State Department of Health, 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.