sidecar health

MAJOR MEDICAL EXPENSE INSURANCE POLICY – OHIO PLAN

Sidecar Health Insurance Company
One Columbus, Suite 495,10 West Broad St., Columbus, OH 43215-3484
1-877-653-6440
www.sidecarhealth.com
Effective Date: January 1, 2023

Sidecar Health Ohio Plan
(See Any Doctor + Premium Member Support)

NOTICE OF RIGHT TO EXAMINE POLICY FOR 10 DAYS

You may return this Policy to Us or to the agent through whom it was purchased within 10 days of its delivery if, after examination of the Policy, You are not satisfied with it for any reason. Upon return, We will refund all Premium paid by You, including any policy fees or other charges. The Policy shall be void from the beginning and the parties shall be in the same position as if no policy had been issued.

Sidecar Health is a Qualified Health Plan issuer in the Federal Health Insurance Marketplace.

SIDECAR HEALTH INSURANCE COMPANY

("Sidecar Health")
a stock company domiciled in the State of Ohio

MAJOR MEDICAL EXPENSE INSURANCE POLICY

We issued this Policy in consideration of Your application and payment of the first Premium. A copy of Your application is attached and is made a part of the Policy. We will pay Benefit Amounts to You for covered Loss due to illness or injury as outlined in this Policy. Benefits are subject to Policy definitions, provisions, limitations, and exclusions. This Policy is a legal contract between You and Sidecar Health Insurance Company.

IMPORTANT NOTICES:

- **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.**
- **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 US.**

THIS POLICY IS GUARANTEED RENEWABLE

This coverage is guaranteed renewable unless otherwise terminated by Us as permitted by this Policy or by You upon 30 days prior written notice to Us.

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

This Policy is issued in, and governed by the laws of, the State of Ohio.

Patrick G. Quigley
Chief Executive Officer
Sidecar Health Insurance Company

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SECTION 1 – INTRODUCTION

Welcome to Sidecar Health. You chose this new journey with Sidecar Health because of Our member-first mission. We are called Sidecar Health because We put You in the driver's seat for Your health care, but We are always at Your side. We are excited You chose Us. We look forward to partnering with You to improve health insurance as We know it.

Sidecar Health works differently than traditional insurance. With Sidecar Health, You shop for health care as You do for other important things in Your life. The benefits in this Plan are designed to help cover Your healthcare expenses for Medically Necessary services and supplies. With Sidecar Health, You will know the Benefit Amount for each Covered Service, and You see what healthcare Providers charged other members for care. By using Our Sidecar Health VISA benefit card (Benefit Card) You become part of a community that shared information about where they found excellent care at good prices.

As this is a different approach to health insurance, it is important for You to read this Policy completely and carefully to understand how this Plan works. We want You to get the most of this coverage. We believe smart healthcare shoppers are the best shoppers. The information in this Policy will help You understand how to use Your coverage.

In this Policy, defined terms are included in **DEFINITIONS, Section 4**, and will be capitalized whenever the terms are used. You will find more information, including contact information and how to use Your coverage and the Benefit Card in **MEMBER CARE, Section 3**. Some key aspects of this Plan include:

- This Policy includes Deductibles. This Policy does not include other common cost-sharing mechanisms, such as copayments or coinsurance.
- This Policy does not use a Provider network. You can receive medical services and Prescription Drugs from any licensed Provider. We pay a set Benefit Amount for each Covered Service. The Benefit Amount is the same regardless of what Provider You see or what that Provider charges. Providers may Balance Bill You if they charge an amount greater than the Benefit Amount. In most circumstances, We are not required to pay any amount in excess of the Benefit Amount.
- You are encouraged to call Providers and pharmacies before seeking services. Ask the Provider for their cash price. In the Sidecar Health app and website You can learn what other members have paid for similar services. You can also see the amount We will pay as the Benefit Amount for each Covered Service.
- You may use the Benefit Card to pay Providers at point-of-service and take advantage of discounts for “self-pay” or “cash” pay patients, without network restraints.
- We will treat every charge to the Benefit Card as an Estimated Benefit for the service. You are responsible for providing Us the Medical Invoice as Proof of Loss after You receive the service. We adjudicate, or process, the claim from the Medical Invoice. We then finalize the Benefit Amount associated with the service or Prescription Drug.

Please refer to the actual terms of this Policy for details. If You have questions, contact Us at Our toll-free number, 1-877-653-6440.

SECTION 2 – IMPORTANT CONTACT INFORMATION

I Need To	Contact Information	Available Hours
Locate the Website	www.sidecarhealth.com	24 hours per day 7 days per week
Ask a Coverage Question, or verify Coverage for a Provider	www.sidecarhealth.com	24 hours per day 7 days per week
Ask a Billing Question	www.sidecarhealth.com	24 hours per day 7 days per week
Find a Provider	www.sidecarhealth.com	24 hours per day 7 days per week
Find a Benefit Amount	https://app.sidecarhealth.com/previewCoverage Toll Free: 1-877-653-6440	Web: 24 hours per day 7 days per week Phone: Mon-Fri 7 a.m.-10 p.m. Sat-Sun 9 a.m.-5 p.m.
Ask a Question about Emergency Services	www.sidecarhealth.com	Web: 24 hours per day 7 days per week Phone: Mon-Fri 7 a.m.-10 p.m. Sat-Sun 9 a.m.-5 p.m.
Activate my Benefit Card for Preventive Services	www.sidecarhealth.com	24 hours per day 7 days per week
File an Appeal or Grievance	www.sidecarhealth.com Fax: 1-866-376-2053	24 hours per day 7 days per week
Submit my Pre-bill	www.sidecarhealth.com Fax: 1-866-376-2053	24 hours per day 7 days per week
Submit my Medical Invoice	www.sidecarhealth.com Fax: 1-866-376-2053	24 hours per day 7 days per week
Report suspected fraud?	Anonymous Hotline 1-855-512-0438 *All Calls are Confidential*	24 hours per day 7 days per week

SECTION 3 - MEMBER CARE USING YOUR SIDECAR HEALTH PLAN

Find Your Provider

As a Sidecar Health member, You may see any Provider that accepts direct payment for services. Call the Provider You want to see. Confirm they accept cash payment for services, and ask what they charge for Your type of visit.

To price shop, call a Provider You used in the past and a few other local Providers before receiving health services, and ask for their cash-pay or self-pay price. For more complex procedures, it's helpful to get those prices in writing. Look up the services You're seeking on the Sidecar Health app or website to determine the Benefit Amount for those services. You'll get the same Benefit Amount(s) no matter which Provider You see. You can always look up a service's Benefit Amount on the Sidecar Health app or website before You get care.

Before You leave Your Provider's office, get an itemized Medical Invoice describing the services You received and paid. This invoice should include "CPT" or other medical billing codes for all provided services. At the pharmacy, ask for a bill that displays the NDC codes as well as the dosage and supply of the medication You are purchasing. Take a picture of Your Medical Invoice and send it to Sidecar Health. For Prescription Drugs, also sending a picture of the bottle or box the medication came in may help Us take care of Your claim more quickly.

If You've shopped around and can't find an available Provider who charges the Benefit Amount in Your area, call Your Member Care team. We'll work with You to locate someone in Your area who charges the Benefit Amount, or help You get to a Provider who does. Be sure to let Us know whether You're looking for routine care or if Your need is more urgent. If You're experiencing an Emergency, call 9-1-1 and get to an Emergency Room first!

Check out Our Help Desk https://sidecarhealth.zendesk.com/hc/en-us for Frequently Asked Questions (FAQs).

Swipe Limits

As defined and described below, Our Benefit Card is designed to protect You from charging large expenses to Your Sidecar Health account without first knowing the Benefit Amount. Therefore, in a Provider's office and at a pharmacy, the Swipe Amount will be limited to amounts set forth in Your Schedule of Benefits

Preventive Care Services

Need a well child visit for Your toddler? Time for Your annual physical or OB/GYN appointment? Preventive Services (described below) are covered without Cost-Sharing on Your Plan. Schedule Your service, then call Member Care before You go. We will activate the Benefit Card so it charges Sidecar Health directly, regardless of whether You've met Your Deductible. Upload the Medical Invoice for the visit. If You receive Covered Services during the visit that are not Preventive Care or that exceed the Benefit Amount, or if You receive services not covered under this Policy, You may be responsible for any pre-Deductible charges or Balance Bill amounts.

Accessing Emergency Services

We know in an Emergency You don't have time to shop for care. Under the federal No Surprises Act and state surprise billing laws and regulations, Sidecar Health works with Your Emergency or Ambulance services Provider to ensure You are not subject to any Balance Billing above Your Deductible. If You have to go to the Emergency Room, show them Your Sidecar Health virtual I.D. card, and instruct the Provider Facility to bill Us directly. For Emergency and Ambulance services, You should know Providers are legally prohibited from billing You or holding You liable for any amount that exceeds "in- network" cost-sharing. (See **NO SURPRISES ACT, Section 14** below.)

Pre-Bills

Submitting a Pre-Bill to Sidecar Health helps You be ready for planned healthcare services or Prescription Drugs that cost more than the Swipe Limit. Your Medical Practitioner or Provider Facility may want You to make a deposit prior to receiving an Inpatient Service, such as a joint replacement, or an Outpatient Service such as a breast biopsy. Even if they don't require any payment in advance, it's a good practice to ask for a Pre-Bill. Submitting Your Pre-Bill to Us before You receive the service allows Sidecar Health to review the Pre-Bill, and alert You to any charges or services You can reasonably expect are typically provided along with the procedure You're getting. Submitting a Pre-Bill can also help You anticipate a possible side effect or outcome. Finally, We will provide You with the Benefit Amounts associated with each of the charges. We recommend You go over the Pre-Bill carefully with Your Provider so You know what to expect.

Unplanned Events

In health care, We try to plan for all potential outcomes. But sometimes You can't anticipate every aspect of a planned procedure or healthcare service. Submit Your Pre-Bill for Our review of Your planned Inpatient or Outpatient procedure. When You submit Your Proof of Loss, We will compare Your Pre-Bill with Your final Medical Invoice to determine whether something unexpected, for which You did not have time to shop for care, happened during that Covered Service. In the event something unexpected happened during Your planned service, such as a different, higher cost, anesthesiologist provided Your anesthetic care, We will work with Your Provider to ensure You don't pay more than the Benefit Amount for that service.

SECTION 4 – DEFINITIONS

In this Policy, capitalized words are defined below. Words not capitalized will be given their ordinary meaning, or otherwise defined in the section in which they are used. When used in this Policy:

Acute Rehabilitation means two or more different types of therapy provided by one or more Rehabilitation Medical Practitioners and performed for three or more hours per day, five to seven days per week, while the Covered Person is confined as an Inpatient in a Hospital, Rehabilitation Facility, or Extended Care Facility.

Adverse Benefit Determination means a decision by Us:

(1) To deny, reduce, or terminate a requested healthcare service or payment in whole or in part, including all of the following:
   (a) A determination, upon application of any Utilization Review technique, that the healthcare service does not meet Our requirements for: medical necessity; appropriateness; health care setting; level of care; or effectiveness; including experimental or investigational treatments.
   (b) A determination of Your eligibility for individual health insurance coverage to participate in a plan or health insurance coverage.
   (c) A determination that a healthcare service is not a Covered Service.
   (d) The imposition of an exclusion, including source of injury, or any other limitation on benefits that would otherwise be covered.

(2) Not to issue individual health insurance coverage to an applicant.

(3) To rescind individual health insurance coverage issued to You.

Ambulance means any vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured, and staffed by Emergency Medical Technicians (EMT), paramedics or other certified medical professionals.

Balance Billing and Balance Bill means medical expenses charged by Your Provider that exceed the Benefit Amount. In most cases, You are responsible for paying the Balance Bill. Balance Billing amounts are not considered Cost-Sharing and do not accrue toward the Deductible or Out-of-Pocket Maximum. In an Emergency Services situation, Balance Billing is considered "Surprise Balance Billing" or "Surprise Billing."

Benefit Amount means the amount We determine We will pay for eligible Covered Services. The Benefit Amount for each eligible Covered Service is approximately equal to 100% of the amount We have determined, through various data sources, including average market amounts charged in Your area, to be what an average healthcare provider will accept as cash payment for a given service.

You will be responsible to any Provider for any amount billed greater than the amount We determine to be the Benefit Amount as described below, except as specifically described in this Policy.

You can see the amount We will pay as the Benefit Amount for any Covered Service in the Sidecar Health app, on the Sidecar Health website at https://app.sidecarhealth.com/previewCoverage or by contacting Us via the toll-free number, 1-877-653-6440.

Benefit Amount for Emergency Care and Ambulance

For Emergency Care and Ambulance, an eligible Benefit Amount will be determined by Us as the greater of:

(1) The Benefit Amount for the Covered Service as determined by Us;

(2) 100% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market; or

(3) An amount as required by applicable federal and/or state Surprise Billing regulations, including amounts based on an All-Payer Model Agreement under Section 1115A of the Social Security Act when applicable. When required for Emergency Care and Ambulance, the Benefit Amount may be adjusted to comply with applicable federal and/or state Surprise Billing regulations.

For additional information regarding Emergency Care and Ambulance billing, please see Emergency Care Services in **MEMBER CARE, Section 3**, and **COVERED SERVICE BENEFITS, Section 5** below, as well as information regarding the federal **NO SURPRISES ACT, Section 14**.

Benefit Card means Our Sidecar Health VISA benefit card issued to You by Us. The Benefit Card may only be used to pay for a Covered Service as defined in the Policy and for no other purchases. If We suspect fraud or have evidence the Benefit Card is being used in a fraudulent manner, We may, at Our discretion, suspend the use of the Benefit Card. Suspension of the Benefit Card does not limit Your ability to obtain benefits for eligible Covered Services.

Calendar Year means the period beginning on the initial effective date of this Policy and ending December 31 of that year. For each following year it is the period from January 1 through December 31.

Chiropractic Care means treatment that involves neuromuscular treatment in the form of manipulation and adjustment of the tissues of the body; particularly of the spinal column; and may include physical medicine modalities or use of Durable Medical Equipment. As used in this Policy, Chiropractic Care includes manipulation therapy.

Continuous Loss means that Covered Service Expenses are continuously and routinely being incurred for the active treatment of an illness or injury. The first Covered Service Expense for the illness or injury must have been incurred before coverage of the Covered Person ceased under this Policy. Whether Covered Service Expenses are being incurred for the active treatment of the covered illness or injury will be determined by Us based on Generally Accepted Standards of Medical Practice.

Cosmetic Treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an injury, illness, or congenital anomaly.

Cost-Sharing means the amounts You must pay for Covered Services, expressed in this Policy as Deductibles. This Plan does not include any other cost-sharing mechanism; no copayments or coinsurance are associated with this Plan.

Covered Person means anyone:

(1) Named in the application for whom You are requesting coverage;

(2) For whom We agree in writing to issue coverage or add as a Covered Person; and

(3) In the case of a newborn or adopted Eligible Child, such Eligible Child during the first 31 days after birth or placement.

Covered Service or Covered Service Expenses means any drug, procedure, service, supply or treatment as described in this Policy, performed, prescribed, directed or authorized by a Physician, or other Medical Practitioner more specifically indicated in a particular benefit description in this Policy. To be an eligible Covered Service the drug, procedure, service, supply or treatment must be:

(1) Provided or incurred while the Covered Person's coverage is in force under this Policy;
(2) Covered by a specific benefit provision in this Policy;
(3) Medically Necessary or otherwise Preventive Care;
(4) With regard to medical services provided by a Medical Practitioner, services rendered within the scope of the Medical Practitioner's license or certification; and
(5) Not excluded anywhere in this Policy.

Custodial Care means treatment designed to assist a Covered Person with activities of daily living that can be provided by a layperson, is not specific treatment for an illness or injury and cannot be expected to substantially improve a medical condition. Custodial Care is generally excluded under this Policy and includes (but is not limited to) the following:

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

Deductible means the amount You owe each Calendar Year before We begin to pay for Covered Services, as listed in Your Schedule of Benefits. The Deductible may not apply to all Covered Services. You satisfy the Deductible by paying the Benefit Amount(s) set by Us that will be paid by Sidecar Health for a particular Covered Service once Your Deductible is met. Balance Billing amounts do not accrue (or count) toward the Deductible.

Dental Services means Surgery or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances. Expenses for such treatment are considered Dental Services regardless of the reason for the services. This Policy does not cover adult Dental Services, as described below in **GENERAL LIMITATIONS AND EXCLUSIONS, Section 6**.

Dependent means Your Spouse and/or an Eligible Children who are covered under this Policy.

Durable Medical Equipment means items used to serve a specific diagnostic or therapeutic purpose in the treatment of an illness or injury, can withstand repeated use, are generally not useful to a person in the absence of illness or injury, and are appropriate for use in the patient's home.

Effective Date means the date Your coverage begins under this Policy.

Eligible Cancer Clinical Trial means a cancer clinical trial that meets all of the following criteria:

(1) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes;
(2) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes;
(3) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology;

(4) The trial does one of the following:
   (a) Tests how to administer a health care service, item, or drug for the treatment of cancer;
   (b) Tests responses to a health care service, item, or drug for the treatment of cancer;
   (c) Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
   (d) Studies new uses of a health care service, item, or drug for the treatment of cancer; and

(5) The trial is approved by one of the following entities:
   (a) The National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
   (b) The FDA;
   (c) The United States Department of Defense; or
   (d) The United States Department of Veterans' Affairs.

Eligible Child means a Subscriber's or Spouse's child if that child is less than 26 years of age, or age 28 under certain circumstances, as shown in the ONGOING ELIGIBILITY section. As used in this definition, "child" means:

(1) A natural child;
(2) A legally adopted child;
(3) A stepchild;
(4) A child placed with a Subscriber or Spouse for adoption; or
(5) A child for whom legal guardianship has been awarded to a Subscriber or Spouse.

It is Your responsibility to notify Us if Your child ceases to be an Eligible Child. You must reimburse Us for any benefits We provide or pay for a child at a time when the child did not qualify as an Eligible Child.

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

(1) 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;
(2) Serious impairment to bodily functions; or
(3) Serious dysfunction of any bodily organ or part.

Emergency Care means the following:

(1) Under federal law, a medical screening examination 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; and
(2) Any further medical examination and treatment required by federal law to Stabilize an Emergency Medical Condition and within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

(3) As used in this definition, "Stabilize" means to provide medical treatment of the Emergency Medical Condition that may be necessary to assure, within reasonable probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to an Emergency Medical Condition for a pregnant woman who is having contractions, to cause them to deliver (including the placenta) during such transfer. See also, definition of Medically Stabilized.

Estimated Benefit means the temporary advance of benefits equal to the Swipe Amount that are paid by Us when You use the Benefit Card before We receive a Medical Invoice for the Covered Service.

Experimental or Investigational Treatment means a treatment, drug, device, procedure, supply or service and related services (or any portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists:

(1) The treatment, drug, device, procedure, supply or service is in any clinical trial or a Phase I, II or III trial.

(2) The treatment, drug, device, procedure, supply or service is not yet fully approved or recognized (for other than experimental, investigational, research or clinical trial purposes) by the National Cancer Institute (NCI), FDA, or other pertinent governmental agency or professional organization.

(3) The results are not proven through controlled clinical trials with results published in peer-reviewed English language medical journals, to be of greater safety and efficacy than conventional treatment, in both the short and long term.

(4) The treatment, drug, device, procedure, supply or service is not generally accepted medical practice in the state where the Insured resides or as generally accepted throughout the United States as determined in Our discretion, by reference to any one or more of the following: peer-reviewed English language medical literature, consultation with Physicians, authoritative medical compendia, the American Medical Association, or other pertinent professional organization or governmental agency.

(5) The treatment, drug, device, procedure, supply or service is described as investigational, experimental, a study, or for research or something similar, in any consent, release or authorization the Covered Person, or someone acting on their behalf, may be required to sign.

The fact that a procedure, service, supply, treatment, drug, or device may be the only hope for survival will not change the fact it is otherwise experimental in nature.

Extended Care Facility means an institution, or a distinct part of an institution, that:

(1) Is licensed as a Hospital, extended care facility, or Rehabilitation Facility by the state in which it operates;

(2) Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a Physician and the direct supervision of a registered nurse;

(3) Maintains a daily record on each patient;

(4) Has an effective Utilization Review plan;

(5) Provides each patient with a planned program of observation prescribed by a Physician; and

(6) Provides each patient with active treatment of an illness or injury, in accordance with existing standards of medical practice for that condition.

Extended Care Facility does not include a facility primarily for rest, the aged, treatment of Substance Abuse, Custodial Care, or for care of Mental Health Disorders or the mentally incompetent.

FDA means the United States Food and Drug Administration.

Generally Accepted Standards of Medical Practice means standards based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials. If no credible scientific evidence is available, then standards are based on physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is Medically Necessary and is a Covered Service under the Policy. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by Us.

Grievance means any dissatisfaction with Us or the administration of this Policy by Us that is expressed in writing in any form to Us by, or on behalf of, a Covered Person including any of the following:

(1) Provision of services;
(2) Determination to reform or rescind a policy; or
(3) Claims practices.

A Grievance related to an Urgent Care Request that triggers expedited review does not have to be in writing.

Home Health Aide Services means those services provided by a home health aide employed by a Home Health Care Agency and supervised by a registered nurse, which are directed toward the personal care of a Covered Person.

Home Health Care means care or treatment of an illness or injury at the Covered Person's home that is:

(1) Provided by a Home Health Care Agency; and
(2) Prescribed and supervised by a Physician.

Home Health Care Agency means a public or private agency, or one of its subdivisions, that:

(1) Operates pursuant to law as a home health care agency;
(2) Is regularly engaged in providing Home Health Care under the regular supervision of a registered nurse;
(3) Maintains a daily medical record on each patient; and
(4) Provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing standards of medical practice for the injury or illness requiring the Home Health Care.

Hospice means an institution that:

(1) Provides a Hospice Care Program;
(2) Is separated from or operated as a separate unit of a Hospital, Hospital- related institution, Home Health Care Agency, mental health facility, Extended Care Facility, or any other licensed health care institution;
(3) Provides care for the Terminally Ill; and
(4) Is licensed by the state in which it operates.

Hospice Care Program means a coordinated, interdisciplinary program prescribed and supervised by a Physician to meet the special physical, psychological, and social needs of a Terminally Ill Covered Person and those of his or her Immediate Family.

Hospital means an institution that:

(1) Is operated pursuant to state or federal law;
(2) Is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an Inpatient basis;
(3) Is under the supervision of a staff of Physicians;
(4) Provides 24-hour nursing service by or under the supervision of a registered nurse;
(5) Has medical, diagnostic and treatment facilities, with major surgical facilities; a) on its premises; or b) available to it on a prearranged basis; and
(6) Charges for its services.

A Hospital does not include:

(1) A clinic or facility for:
    a. convalescent, Custodial Care, educational care, or nursing care, or
    b. the aged; or

(2) A military or veteran's hospital or a hospital contracted for or operated by a national government or its agency unless:
    a. the services are rendered on an Emergency basis; and
    b. a legal liability exists for the charges made to the Covered Person for the services given in the absence of insurance.

Immediate Family means a person related to a Covered Person in any of the following ways: Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild), or any individual who lives in the Covered Person's household.

Inpatient means a person who is provided Covered Services while an overnight registered patient of a Hospital or other facility, using and being charged for room and board.

Intensive Care Unit means a designated ward, unit or area within a Hospital that incurs a specified additional daily surcharge and that is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within the Hospital.

Intensive Day Rehabilitation means two or more different types of therapy provided by one or more Rehabilitation Medical Practitioners and performed for three or more hours per day, five to seven days per week.

Licensed Mental Health Professional means a professional that holds a clinical license in a behavioral health discipline; and possesses the training or experience to complete the required evaluation and treatment of behavioral health disorders pursuant to state law.

Life Threatening Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Loss means an event or service for which benefits are, or may be, payable under this Policy. A Loss must occur while the Covered Person is covered under this Policy.

Managed Drug Limitations means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

Medical Invoice means the fully itemized bill or document provided for medical services rendered by a Provider to a Covered Person. The Medical Invoice may be a CMS 1500 form (formerly known as HCFA 1500), or CMS 1450 (also known as UB-04), or the claim form provided by Us. A Medical Invoice is submitted as Proof of Loss and must be in a form that specific enough to identify all of the following:

(1) the CPT or other relevant medical billing codes, such as HCPCS/DRG/NDCs, for Covered Service(s) including any medical code modifiers when applicable;
(2) the reason for the service(s) (including all ICD-10 diagnosis codes);
(3) the amount charged for such service(s);
(4) the Provider's name and National Provider Identifier (NPI) number;
(5) the patient's name; and
(6) the date(s) of the service.

Please note for Pharmacy Medical Invoices, the relevant NDC or GPI codes, as well as the dosage and days-supply are also necessary to quickly process Your Claim.

To be considered for Claim processing, the Medical Invoice must follow appropriate billing/coding practices, indicating the services You or Your Covered Dependent received. If We cannot properly identify the services billed by Your Provider, We may return the Medical Invoice for additional information, or deny Your Claim.

Medical Practitioner means an appropriately-licensed, accredited or certified: Physician; optometrist; social worker; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or other health care practitioner licensed, accredited or certified to perform health care services consistent with state law. Medical Practitioners are broadly considered Providers under this Policy, and their services must be rendered within the lawful scope of practice for that type of Provider to be a Covered Service.

The following are examples of providers that are NOT Medical Practitioners, by definition of the Policy: acupuncturist; rolfer; hypnotist; naturopath; perfusionist; massage therapist; or sociologist.

Medically Necessary or Medical Necessity means any drug, procedure, service, supply or treatment authorized by a Provider, including a Physician, or other Medical Practitioner more specifically indicated in a particular benefit description in this Policy, to diagnose and treat a Covered Person's illness or injury that:

(1) Is consistent with the symptoms or diagnosis;
(2) Is provided according to Generally Accepted Standards of Medical Practice;
(3) Is not Custodial Care;
(4) Is not solely for the convenience of the Provider or the Covered Person;
(5) Is not Experimental or Investigational Treatment;
(6) Is provided in the most cost-effective care facility or setting;
(7) Does not exceed the scope, duration, or intensity of the level of care needed to provide safe, adequate and appropriate diagnosis or treatment;
(8) Without which, the Covered Person's illness or injury would be adversely affected; and

(9) In regard to Hospital confinement, the diagnosis and treatment of the Covered Person's medical symptoms or conditions cannot be safely provided as an outpatient.

A drug, procedure, service, supply, or treatment that is not Medically Necessary is not an eligible Covered Service or Covered Service Expense. The fact that a Provider may prescribe, order, recommend or approve a drug, procedure, service, supply or treatment, **does not** make it Medically Necessary or a Covered Service and does not guarantee the payment of a Benefit Amount.

We will determine Medical Necessity upon receipt of Your Medical Invoice for a Covered Service. In some cases, We may require Your medical records to determine Medical Necessity.

Once We receive Your Medical Invoice and have all necessary documentation, We will determine whether the service is a Covered Service and whether it is Medically Necessary. In the event We determine the service was not Medically Necessary, We will deny the claim and You will have the right to appeal Our determination.

Medically Necessary Medical Supplies means medical supplies that are:

(1) Medically Necessary to the care or treatment of an injury or illness;
(2) Not reusable or Durable Medical Equipment; and
(3) Not able to be used by others.

Medically Necessary Medical Supplies do not include: first aid supplies, cotton balls, rubbing alcohol, or similar items routinely found in the home; over-the-counter arch supports; doughnut cushions; hot packs/ice bags; vitamins (unless prescribed by a Provider as Preventive); or auto-injectors.

Medically Stabilized means that no material deterioration of the Emergency Medical Condition is likely, within reasonable medical probability, to result from or occur during the transfer of an individual from a facility or, with respect to an Emergency Medical Condition for a pregnant woman who is having contractions, that the woman has delivered (including the placenta).

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

Mental Health Disorder means a behavioral, emotional, or cognitive pattern of functioning in an individual associated with distress, suffering, or impairment in one or more areas of life.

Notice of Claim means formal information You provide to Us to let Us know You intend to file a request for reimbursement for a Covered Service. You submit a "Notice of Claim" when You Swipe Your Benefit Card to pay a Medical Practitioner or other Provider at the point-of-service. Submission of Your Medical Invoice or Proof of Loss also serves as "Notice of Claim" so long as it is within 90 days of the service.

Orthotic Device means a rigid or semi-rigid device used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

Other Plan means any plan or policy that provides insurance, reimbursement, or service benefits for hospital, surgical, or medical expenses. This includes insurance and other payment programs, including: (1) group or individual insurance policies; (2) automobile no-fault or medical pay; (3) homeowner insurance medical pay or premises medical pay; (4) nonprofit health service plans; (5) health maintenance organization subscriber policies; (6) self-insured group plans; (7) prepayment plans; (8) and Medicare when the Covered Person is enrolled in Medicare. Other Plan does not include Medicaid.

Out-of-Pocket Maximum (also known a Maximum Out-of-Pocket or MOOP) means the most You must pay for Covered Services during a Calendar Year before We begin to pay 100% of the Benefit Amount for Covered Services. The Out-of-Pocket Maximum is an amount equal to the Deductible, as shown in the Schedule of Benefits. This limit never includes Your Premium or Premium payments, the cost of health care services We do not cover, or Balance Billing.

Once an individual's Out-of-Pocket Maximum amount is met, We pay 100% of the eligible Benefit Amounts for Covered Services for that individual.

The family Out-of-Pocket Maximum amount is two times the individual Out-of-Pocket Maximum amount. Deductible amounts paid by each individual enrolled in Your Policy go toward meeting the family Out-of-Pocket Maximum amount. The remainder of the family Out-of-Pocket Maximum amount can be met with the combination of any amounts paid toward one or more other Covered Persons' individual Deductibles.

Once the family Out-of-Pocket Maximum is met, We will pay 100% of the eligible Benefit Amounts for Covered Services for all Covered Persons in the family.

Outpatient means other than Inpatient.

Outpatient Surgical Facility means any facility with a medical 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 and 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 Medical Practitioner.

Pain Management Program means a program using interdisciplinary teams providing coordinated, goal-oriented services to a Covered Person who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the health care system. A Pain Management Program must be individualized and provide physical Rehabilitation, education on pain, relaxation training, and medical evaluation.

Period of Extended Loss means a period of consecutive days:

(1) Beginning with the first day on which a Covered Person is a Hospital Inpatient; and
(2) Ending with the 30th consecutive day for which he or she is not a Hospital Inpatient.

Personal Account means a credit card, debit card or other account You authorize to be linked to the Benefit Card and debited by Us to facilitate payment of:

(1) A Swipe Amount prior to Your Deductible being met,
(2) The amount of a Medical Invoice that exceeds the Benefit Amount(s) payable under this Policy for Covered Service(s) as identified on the Medical Invoice, considered Balance Billing (defined above); and
(3) The cost of any additional services not considered Covered Services or determined to be not Medically Necessary.

Physician means any person who is a licensed, accredited, or certified medical physician (M.D. or D.O.), clinical psychologist, podiatrist, dentist, chiropractor, physician's assistant, or nurse practitioner. As such, a Physician must be acting within the scope of their license, accreditation, or certification under the laws in the state in which they practice and provide only those medical services within the scope of their license, accreditation, or certification. It does not include the Covered Person treating themselves. A Physician is also broadly considered a "Provider" under this Policy.

Physician Home Visits and Office Visits means medical care and consultations to examine, diagnose, and treat an illness of injury performed by a Physician in Your home or their office. Physician Home Visits are not considered Home Health Care visits or Coverage (see below).

Policy when capitalized, means this Policy issued by Sidecar Health Insurance Company and delivered to You. It includes the Schedule of Benefits, attached pages and riders, the applications, and any amendments. The Policy may also be referred to as **Plan**.

Portal means any website, mobile application, or other digital platform identified by Sidecar Health through or by which You may engage with Us. Through the Portal, You may access Benefit Amount information. You may provide a Notice of Claim and submit Proof of Loss. You may search and download forms. You may change Your account elections. The account election may include withdrawal of Your consent to electronic communication. You may also exchange information with Us.

Post-Stabilization Care under federal law, means emergency care provided at a Hospital or other Emergency facility until a Physician determines the patient can travel safely to another facility using non-medical transport, the facility is available and will accept the transfer, and the transfer will not cause the patient other unreasonable burdens. The patient must receive written notice and give written consent to be transferred.

Pre-Bill means a list of services and associated charges Your Provider, including a pharmacist or pharmacy, anticipates could be Reasonably Expected as part of a planned/scheduled Inpatient or Outpatient procedure. You may submit a Pre-Bill to Us to authorize a payment larger than the Swipe Limit, and any time in advance of payment or down-payment and before the services are performed. You should carefully review the Pre-Bill with Your Provider to ensure You understand the possible complications and what they cost. We will use the Pre-Bill to compare to Your submitted Proof of Loss to determine whether You were charged for Unplanned Events

As You review the Pre-Bill with Your Provider, You should consider the following categories of services/charges, including but not limited to:

(1) Physician (professional) fees
(2) Lab fees/pathologist
(3) X-Ray or other imaging fees
(4) Facility charges
(5) Pharmacy fees
(6) Hospital-administered drugs
(7) Other provider fees
    (a) Anesthesiologist
    (b) Radiologist
(8) Other services identified by the Provider and considered part of or possible during the planned procedure.

Premium means the amount that must be paid for health insurance coverage under this Policy.

Prescription Drug means any medicinal substance whose label is required to bear the legend "RX only."

Prescription Order means the request for each separate drug or medication by a Physician or each authorized refill of such requests.

Preventive Care means the preventive care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HSRA); items or services that have an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF); and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP). See PREVENTIVE CARE COVERAGE in **COVERED SERVICE BENEFITS, Section 5** below.

Primary Care Physician means a Physician who is a family practitioner, general practitioner, pediatrician, obstetrician-gynecologist, or internist.

Private Duty Nursing Services means nursing services that include skilled nursing 24 hours a day, seven days a week, under the supervision of a registered nurse, at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. The service provided must be directed towards the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge.

Proof of Loss means the Medical Invoice and any other information required by Us to determine whether a claim is payable and the payable Benefit Amount. It includes, but is not limited to, the Medical Invoice, claim forms, medical bills or records, and Other Plan information when necessary for Coordination of Benefits. When applicable, Proof of Loss must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare. Some Providers may refer to the Medical Invoice as the "Superbill." In the case of pharmacy Proof of Loss, documentation including the NDC or GPI codes, as well as dosage and days-supply, assist Sidecar Health in quickly handling Your Claim. Proof of Loss is sometimes referred to as "Proof of Care."

Prosthetic Device means an artificial substitute for a body part. Prosthetic Devices include tissues and materials inserted into tissue for functional or therapeutic purposes.

Provider means a Home Health Care Agency, Licensed Mental Health Professional, Medical Practitioner, Physician, Provider Facility, or Rehabilitation Medical Practitioner.

Provider Facility means an Extended Care Facility, Hospice, Hospital, Outpatient Surgical Facility, Rehabilitation Facility, or Residential Treatment Facility.

Reasonably Expected means an additional service, side effect, or outcome that was capable of being anticipated based on the advice of internal clinical leadership (the Sidecar Health Medical Director) as well as generally accepted standards of medical practice, including peer-reviewed medical literature, clinical standards, and medical guidelines and protocols.

Reconstructive Surgery means Surgery performed to correct significant deformities caused by congenital or developmental abnormalities, illness, injury, or an earlier treatment to improve function, even if the Surgery also improves or changes the appearance of a portion of the patient's body.

Rehabilitation means care for restoration (including by education or training) of one's prior ability to achieve some reasonable level of functional ability. This type of care must be Acute Rehabilitation, Sub-Acute Rehabilitation, or Intensive Day Rehabilitation, and it includes Rehabilitation Therapy and Pain Management Programs. An Inpatient hospitalization will be deemed to be for Rehabilitation at the time the patient has

been Medically Stabilized and begins to receive Rehabilitation Therapy or treatment under a Pain Management Program.

Rehabilitation Facility means an institution or a separate identifiable Hospital unit, section, or ward that:

(1) Is licensed by the state as a Rehabilitation Facility; and

(2) Operates primarily to provide 24-hour primary care or Rehabilitation of sick or injured persons as Inpatients or on an outpatient basis.

Rehabilitation Facility does not include a facility primarily for rest, the aged, long term care, assisted living, Custodial Care, or for care of the mentally incompetent.

Rehabilitation Medical Practitioner means a Physician, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A Rehabilitation Medical Practitioner must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation Therapy means physical therapy, occupational therapy, speech therapy, respiratory therapy, pulmonary rehabilitation, and cardiac rehabilitation.

Rescission of a policy means a cancellation or discontinuance of coverage that has a retroactive effect back to the original effective date. Rescission does not include a cancellation or discontinuance or coverage that has only a prospective effect or that is effective retroactively due to a failure to timely pay required Premiums or contributions towards the cost of coverage.

Residence means the physical location where You live. If You live in more than one location, and You file a United States income tax return, the physical address (not a P.O. Box) shown on Your United States income tax return as Your residence will be deemed to be Your place of Residence. If You do not file a United States income tax return, the physical address where You spend the greatest amount of time will be deemed to be Your place of Residence.

Residential Treatment Facility means a facility that provides (with or without charge) sleeping accommodations, and:

(1) Is not a Hospital, Extended Care Facility, or Rehabilitation Facility; or

(2) Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

A Residential Treatment Facility must provide a continuous, structured program of mental health and/or drug or alcohol treatment and rehabilitation, including 24-hour a day nursing care.

Schedule of Benefits means a document, incorporated by reference in this Policy, that describes Deductibles, Out-of-Pocket Maximum limits, and other limits on Covered Services.

Screening Mammography means a radiologic examination consisting of two views for each breast that has an average radiation exposure delivery of less than one rad mid- breast for the purpose of detecting unsuspected breast cancer at an early stage in asymptomatic women.

Sidecar Health Account means the account maintained by Sidecar Health or its administrator on Your behalf and for the benefit and all Covered Persons under Your Policy.

Skilled Nursing Facility means a facility that mainly provides inpatient care and treatment for persons recovering from an illness or injury; provides care supervised by a Physician; provides 24 hour per day nursing care supervised by a full-time registered nurse; is not a facility primarily for care of the aged, Custodial Care, or treatment of Substance Abuse; and is not a rest, educational, or custodial or similar facility.

Specialist Physician means 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 means Your lawful wife or husband, including a same sex spouse. Spouse also includes a lawful domestic partner.

Sub-Acute Rehabilitation means one or more different types of therapy provided by one or more Rehabilitation Medical Practitioners and performed for one-half hour to two hours per day, five to seven days per week, while the Covered Person is confined as an Inpatient in a Hospital, Rehabilitation Facility, or Extended Care Facility.

Substance Abuse means alcohol, drug or chemical abuse, overuse, or dependency.

Surgery or **Surgical Procedure** means:

(1) An invasive diagnostic procedure; or

(2) The treatment of a Covered Person's illness or injury by manual or instrumental operations, performed by a Physician while the Covered Person is under general or local anesthesia.

Swipe Amount means the amount charged by a Provider and paid by a Covered Person using the Benefit Card. The Swipe Amount is independent of the eligible Covered Service Expense or the Benefit Amount.

Swipe Limit means the maximum dollar amount that can be charged to the Benefit Card without first obtaining Our pre-approval of the transaction amount. The Swipe Limit is set forth on the Schedule of Benefits.

Telemedicine means the delivery of healthcare services through synchronous or asynchronous information and communication technology by a Medical Practitioner, within the scope of the Medical Practitioner's scope of practice, who is located at a site other than the site where the recipient is located. Providers offering Telemedicine in Ohio must be licensed to practice in this state.

Terminally Ill means a Physician has given a prognosis that a Covered Person has six months or less to live. Notwithstanding the foregoing, benefits for an eligible Terminally Ill Covered Person will continue to be paid if such person lives longer than six months.

Third Party means a person or other entity that is or may be obligated or liable to the Covered Person for payment of any of the Covered Person's expenses for illness or injury.

The term "Third Party" includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; or an insurance company. However, the term Third Party will not include any insurance company with a policy under which the Covered Person is entitled to benefits as a named insured person or an insured dependent of a named insured person, except in jurisdictions where statutes or common law does not specifically prohibit Our right to recover from these sources.

Tobacco Use or **Use of Tobacco** means use of tobacco by individuals who use tobacco on average four or more times per week and within no longer than the six months immediately preceding the date application for this Policy was completed by the Covered Person, including all tobacco products but excluding religious and ceremonial uses of tobacco.

Transplant means a transfer of organs, tissues, or cells from one person to another (Allograft) or from one area of the body to another (Autograft) to replace a diseased structure and to restore function of the person.

Unplanned Event means an event such as a surgery or other invasive procedure that takes place during a scheduled covered healthcare service at an Inpatient or Outpatient facility that could not be Reasonably Expected to be part of the service at the time the Covered Person was shopping for care. An Unplanned Event does not include something that could have been foreseen as a reasonable outcome of the scheduled service. Unplanned Events will not appear on a Pre-Bill. These events are distinguishable from Emergencies.

Urgent Care means a medical problem that 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. Examples of Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees).

Urgent Care Center means a facility, not including a Hospital emergency room, freestanding emergency facility, or a Physician's office, that provides immediate, short term medical care, treatment or services without appointment that are required:

(1) To prevent serious deterioration of a Covered Person's health; and

(2) As a result of an unforeseen illness, injury, or the onset of acute or severe symptoms.

Utilization Review means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care 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.

We, Us, Our, and **Ours** means Sidecar Health Insurance Company.

You and **Your** means the Covered Person(s) named on the Schedule of Benefits, including the primary person insured under this Policy and any Dependents.

SECTION 5 – COVERED SERVICE BENEFITS

COVERED SERVICES

A healthcare service will be considered a Covered Service under the terms and conditions of this Plan only when the service satisfies all of the following:

(1) Is Medically Necessary or otherwise specifically included as a Covered Service under this Policy (such as Preventive Care);
(2) Is within the scope for the license of the Provider performing the service;
(3) Is rendered while coverage under this Policy is in force; and
(4) Is Not Experimental or Investigational Treatment or otherwise excluded or limited by this Policy, or by any amendment or rider to this Policy.

Please refer to Your Schedule of Benefits for the Deductibles, day or visit limits, and any other requirements that apply to these Covered Services.

The sections below provide details about eligible Covered Services under this Plan.

Because the benefits We pay are fixed and may be less than a Provider's charge, a Provider may send You a bill for any charges remaining after We have paid You the applicable Benefit Amount (this is called "Balance Billing"). Except in certain circumstances, We cannot prohibit a Provider from Balance Billing You the difference between the Provider's charge for a Covered Service and the applicable Benefit Amount.

ALLERGY TESTING COVERAGE

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

AMBULANCE COVERAGE

We pay benefits for transportation by Ambulance for the treatment of an Emergency as follows:

(1) From the Covered Person's home, scene of accident, or medical Emergency to the nearest Hospital that can provide services appropriate to the Covered Person's condition;
(2) Between Hospitals;
(3) Between a Hospital and Skilled Nursing Facility; or
(4) From a Hospital or Skilled Nursing Facility to the Covered Person's home.

Exclusions to Ambulance Coverage

No benefits will be paid for:

(1) Ambulance service, when not Medically Necessary, except when ordered by an employer, school, fire or public safety official and the Covered Person is not in a position to refuse.
(2) Vehicles that do not meet the definition of Ambulance, including but not limited to ambulettes, van, or taxicab.
(3) Ambulance service when another type of transportation can be used without endangering the Covered Person's health.
(4) Ambulance services provided for a Covered Person's comfort or convenience.
(5) Trips to a Physician's office or clinic, or to a morgue or funeral home.

CANCER SCREENINGS AND CHEMOTHERAPY COVERAGE

We pay benefits for cancer screenings, in addition to Preventive Care screenings described under Preventive Care Coverage below, and chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents prescribed by a Medical Practitioner to kill or slow the growth of cancer cells.

Non-preventive screening mammography

We pay benefits for one Screening Mammography every year for adult women not eligible for the preventive Screening Mammography benefit. We will pay benefits for the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and the professional interpretation of the film.

We will also pay benefits for any additional screening method deemed medically necessary by a treating health care provider for proper breast cancer screening in accordance with applicable American College of Radiology guidelines, including magnetic resonance imaging, ultrasound, or molecular breast imaging if:

(1) The woman's Screening Mammography demonstrates, based on the breast imaging reporting and data system established by the American College of Radiology, that the woman has dense breast tissue; or

(2) The woman is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the woman's health care provider.

CHIROPRACTIC CARE/MANIPULATION THERAPY

We pay benefits for Chiropractic Care used to treat problems associated with bones, joints, and the back. 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 number of Chiropractic Care/Manipulation Therapy services. Manipulation services rendered in the home as part of Home Health Care Services are not covered.

Limitations to Chiropractic Care/Manipulation Therapy Coverage

See the Schedule of Benefits for benefit levels or additional limits.

CLINICAL TRIAL COVERAGE

We pay benefits for services for routine patient care rendered as part of an approved clinical trial if the services are otherwise Covered Services under this Plan. Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved Phase I, II, III or Phase IV clinical trial and when the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other Life-Threatening Condition. Clinical Trial Coverage includes routine patient care for patients enrolled in an Eligible Cancer Clinical trial.

Coverage will include routine patient care costs incurred for:

(1) Drugs and devices approved for sale by the FDA, regardless of whether approved by the FDA for use in treating the patient's particular condition,

(2) Reasonable and Medically Necessary services needed to administer the drug or use the device under evaluation in the clinical trial, and

(3) All items and services otherwise generally available to a Covered Person provided in the clinical trial **except**:

(a) The investigational item, device, or service itself;

(b) Items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the patient;

(c) A service clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

(d) An item or drug provided by the clinical trial sponsors free of charge for any patient;

(e) A service, item or drug that is eligible for reimbursement by a person other than an insurer, including the sponsor of the clinical trial; and

(f) Transportation, lodging, food or other expenses for the patient, or a family member or companion of the patient, associated with the travel to or from a facility providing the clinical trial.

A Covered Clinical Trial must be a study or investigation:

(1) Approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   (a) The National Institutes of Health (NIH);
   (b) The Centers for Disease Control and Prevention;
   (c) The Agency for Health Care Research and Quality;
   (d) The Centers for Medicare & Medicaid Services;
   (e) An NIH Cooperative Group or Center;
   (f) The Federal Departments of Veterans' Affairs or Defense; or
   (g) A qualified research entity that meets the criteria for NIH Center support grant eligibility.

(2) Conducted under an investigational new drug application reviewed by the FDA.

(3) A drug trial exempt under federal law from having such an investigational new drug application.

(4) Conducted under the supervision of a federally-qualified Institutional Review Board (IRB) or similar body.

To be a Covered Clinical Trial, the treating facility and personnel must have the expertise and training to provide the treatment, and treat a sufficient volume of patients. The purpose of the trial should be 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.

Providers participating in clinical trials shall obtain a patient's informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards. Such documents shall be made available to Us upon request.

DENTAL SERVICE COVERAGE

Dental Services Related to Accidental Injury

We pay benefits for Dental Services (including 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. “Initial” dental work means expenses must be incurred within twelve months of the accident or as part of a treatment plan prescribed by a Physician that began within twelve months of the accident. Injury to the natural teeth does not include any injury as a result of chewing or biting. Dental services related to an accidental injury are limited to $3,000 per injury.

Other Dental Services

We pay benefits for the removal of teeth or for other dental processes only if the patient's medical condition or the dental procedure requires a Hospital or Ambulatory Surgery Center setting to ensure the safety of the patient.

Pediatric Dental

See the PEDIATRIC ORAL COVERAGE section within this **COVERED SERVICE BENEFITS, Section 5** of this Policy for covered pediatric Dental Services.

DIABETES COVERAGE

We pay benefits for services and supplies used in the treatment of diabetes. Covered Services include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment; and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; custom-made foot orthotics and specialty shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management; eye examinations; and prescription medication.

DIAGNOSTIC SERVICES AND IMAGING COVERAGE

We pay benefits for diagnostic and advanced imaging services, including but not limited to:

(1) Magnetic Resonance Imaging (MRI)
(2) Computerized tomography scan (CT)
(3) Positron emission tomography (PET scanning)
(4) X-rays
(5) Diagnostic testing using radiologic, ultrasonographic, or laboratory services, related to services within Your Provider's scope of care. Psychometric, behavioral, and educational testing are excluded.

Covered advanced imaging services may change as medical technologies change.

DIALYSIS COVERAGE

We pay benefits for dialysis treatment of an acute or chronic kidney ailment, which may include the supportive use of an artificial kidney machine. This Dialysis Coverage is provided on a non-discriminatory basis whether such treatment is provided in a Hospital or on an outpatient (including home) basis.

DURABLE MEDICAL EQUIPMENT COVERAGE

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

Durable Medical Equipment Coverage includes:

(1) Four (4) mastectomy bras per Calendar Year if the Covered Person has undergone a covered mastectomy.
(2) Rental of a standard hospital bed, a standard walker, a standard wheelchair, a wheelchair cushion, and a ventilator.
(3) One Continuous Passive Motion (CPM) machine per Covered Person following a covered joint surgery.

(4) One wig per Covered Person per Calendar Year necessitated by hair loss due to cancer treatments or traumatic burns.

(5) Contact lenses or glasses following lens implantation.

(6) First pair of eyeglasses or contact lenses per Covered Person which replace the function of the human lens for conditions caused by cataract surgery or injury, but excluding a donor lens.

(7) Medical and surgical supplies for the management of a covered disease or illness.

(8) The rental, or at Our option, the purchase of, Durable Medical Equipment prescribed by a Physician. Repair of the Durable Medical Equipment is also covered. Covered Services include, but are not limited to:

  (a) Hemodialysis equipment;

  (b) Crutches and replacement pads and tips;

  (c) Pressure machines;

  (d) Infusion pump for IV fluids and medicine;

  (e) Glucometer;

  (f) Tracheotomy tube;

  (g) Cardiac, neonatal and sleep apnea monitors; (h) Augmentative communication devices

(9) For dressings, crutches, orthopedic splints, braces, casts, or other Medically Necessary Medical Supplies.

(10) For the initial purchase, fitting and repair of a custom-made Orthotic Device used to support, align, prevent or correct deformities or to improve the function of moveable parts of the body, or that limits or stops motion of a weak or diseased body part. Covered Services include casting, molding, fittings, and adjustments of the Orthotic Device.

(11) One pair of foot Orthotic Device per Covered Person per Calendar Year.

EMERGENCY COVERAGE

If You are experiencing an emergency, call 9-1-1 or go to the nearest Hospital.

We pay benefits for Emergency Care for the treatment of an Emergency Medical Condition in a Hospital or standalone emergency facilities not within a Hospital. You may receive care for an Emergency from any Emergency Provider; however, We will only pay benefits for that Emergency Care that is Medically Necessary, is performed to treat or Medically Stabilize Your Emergency Medical Condition, and Post-Stabilization Care as required by state or federal law. Post-Stabilization Care is a Covered Service as Emergency Care pursuant to terms of the federal No Surprises Act.

We do not pay benefits for 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. Emergency Coverage is provided under this Policy under the rules of the federal No Surprises Act and applicable state law regarding Surprise Billing for Emergency Care Services.

Follow-up care is not considered Emergency Care.

HABILITATIVE THERAPY SERVICES COVERAGE

We pay benefits for health care services or devices that help a person keep, learn, or improve skills and functioning for daily living.

Covered habilitative services include physical therapy, occupational therapy, and speech therapy. These services also include ongoing therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

Additional covered habilitative services to children ages 0 to 21 with a medical diagnosis of Autism Spectrum Disorder ("ASD") include:

(1) Out-patient physical Rehabilitation services performed by a licensed therapist, including speech and language therapy and/or occupational therapy, limited to 20 visits per type of therapy, per year.
(2) Clinical therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to applied behavioral analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan, limited to 20 hours per week.
(3) Mental/behavioral health outpatient services to provide consultation, assessment, development and oversight treatment plans.

Limitations to Habilitation Services Coverage

No benefits will be payable under the ASD benefit subsection for services or treatment that are provided pursuant to an individualized education plan or individualized service plan under state law.

See the Schedule of Benefits for benefit levels or additional limits.

HOME HEALTH CARE COVERAGE

We pay benefits for Home Health Care. Home Health Care includes professional, technical, health aid services, supplies and medical equipment. The Covered Person must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an outpatient basis. Covered Service for Home Health Care are limited to the following charges:

(1) Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
(2) Medical/social services.
(3) Diagnostic services.
(4) Nutritional guidance.
(5) 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 Agency. 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 Agency.
(6) Therapy services (except for Chiropractic Care/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.
(7) Medical/Surgical supplies.
(8) Durable Medical Equipment.
(9) Prescription Drugs (only if provided and billed by a Home Health Care Agency).
(10) Private Duty Nursing Services rendered on an outpatient basis.
(11) Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for Home Health Care.

Limitations to Home Health Care Coverage

See the Schedule of Benefits for benefit levels or additional limits for expenses related to Private Duty Nursing and Home Health Care.

Exclusions to Home Health Care Coverage

No benefits will be payable for charges related to:

(1) Food, housing, homemaker services and home delivered meals.
(2) Home or outpatient hemodialysis services (these are covered under REHABILITATION section of this Policy).
(3) Physician charges (these are covered as Physician Home Visits, see **DEFINITIONS, Section 3**).
(4) Helpful environmental materials (handrails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
(5) Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Agency.
(6) Services provided by a member of the patient's Immediate Family.
(7) 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.

HOSPICE CARE SERVICE COVERAGE

We pay benefits for Hospice Care Services. 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 Care Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice Care Services 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 Covered Person lives longer than six months.

When approved by Your Physician, Covered Services include the following:

(1) Skilled Nursing Services (by an R.N. or L.P.N.).
(2) Diagnostic services.
(3) Physical, speech and inhalation therapies if part of a treatment plan.
(4) Medical supplies, equipment and appliances (benefits will not be covered for equipment when the Covered Person is in a facility that should provide such equipment).
(5) Counseling services.
(6) Inpatient confinement at a Hospice.
(7) Prescription Drugs given by the Hospice.
(8) Home health aide.

Exclusions and Limitations to Hospice Care Service Coverage

No benefits will be payable under this benefit subsection for services provided or expenses incurred for:

(1) Custodial Care, non-skilled convalescent care, or rest cures, even when recommended by a professional or performed in a facility, such as a Hospital, Skilled Nursing Facility or home.
(2) Services provided by volunteers.

(3) Housekeeping services.

HOSPITAL AND INPATIENT HOSPITAL SERVICE COVERAGE

We pay benefits for services obtained in a Hospital. Covered Services include charges from a Hospital, Skilled Nursing Facility, or other Provider for room, board and general nursing services; ancillary services; and professional services from a Physician while an Inpatient. Other Covered Services include:

(1) Daily room and board and nursing services. Benefits are payable for a semi- private room (a room with two or more beds). Benefits are payable for a private room if it is Medically Necessary for the Covered Person to use a private room for isolation and no isolation facilities are available.
(2) Daily room and board and nursing services while confined in an Intensive Care Unit.
(3) Inpatient use of an operating, treatment, or recovery room.
(4) Outpatient use of an operating, treatment, or recovery room for Surgery.
(5) Services and supplies, including drugs and medicines, that are routinely provided by the Hospital to persons while they are Inpatients.
(6) Emergency treatment of an injury or illness, even if confinement is not required.
(7) Professional services of a Medical Practitioner, including for Surgery by an assistant surgeon. This excludes staff consultations required by Hospital rules, consultations required by the patient, routine radiological or cardiographic consultations, telephone consultations, and EKG transmittal via the phone.
(8) Hemodialysis, and the charges by a Hospital for processing and administration of blood or blood components.
(9) Administration of an anesthetic, including anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
(10) Oxygen and its administration.
(11) Medical and surgical dressings, supplies, casts and splints.
(12) Diagnostic services.
(13) Therapy services.

INFUSION THERAPY COVERAGE

We pay benefits for infusion therapy. Infusion therapy 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:

(1) Ordered by a Physician; and
(2) Provided in an office or by an agency licensed or certified to provide infusion therapy.

We pay benefits for home infusion therapy. Benefits for home infusion therapy which are delivered and administered intravenously in the home include:

(1) A combination of nursing;
(2) Durable Medical Equipment; and
(3) Prescription Drug services.

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.

MATERNITY AND NEWBORN COVERAGE

We pay benefits for maternity and newborn care provided by a Physician at a Hospital or birthing center. Covered Services include, for a Covered Person:

(1) Outpatient and Inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and Hospital stays for delivery or other Medically Necessary reasons.

(2) An Inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery.

(3) Services to treat complications of pregnancy.

(4) Services to provide parent education, assistance, and training in breast or bottle feeding and the performance of any 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.

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.

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 the attending Physician, or a certified nurse-midwife attending the mother in collaboration with the Physician, determines further Inpatient postpartum care is not necessary for the mother or newborn child, provided the following are met and the mother consents:

(1) The attending Physician or midwife 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:

   (a) The antepartum, intrapartum, and postpartum course of the mother and infant; or the gestational stage, birth weight, and clinical condition of the infant;

   (b) The demonstrated ability of the mother to care for the infant after discharge; and

   (c) 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 the mother's residence by a Physician or registered nurse performed no later than 72 hours following the mother's and newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

(1) parent education;

(2) assistance and training in breast or bottle feeding; and

(3) 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 the Covered Person's 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 is also covered. Services covered as follow-up care include, without limitation, physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, and performance of any Medically Necessary and appropriate clinical tests.

The coverage applies to services provided in a medical setting or through Home Health Care visits. Home Health Care visit is covered only if the health care provider who conducts the visit is knowledgeable and experienced in maternity and newborn care.

MENTAL HEALTH DISORDER AND SUBSTANCE USE COVERAGE

We pay benefits for services to diagnose and treat Mental Health Disorders and Substance Abuse.

We comply with applicable law governing mental health parity, including but not limited to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Coverage is included on a non-discriminatory basis for all Covered Persons for the diagnosis and Medically Necessary and active treatment of mental, emotional, and substance use disorders and autism spectrum disorders, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or the current ICD-10-CM. Treatment is limited to services prescribed by a Physician in accordance with a treatment plan. Treatment limits for behavioral health expense benefits will be applied in the same manner as physical health service benefits.

Covered Services are included on a non-discriminatory basis for individuals seeking diagnosis and treatment for Mental Health Disorders following any type of assault or violent act, including rape or an assault with intent to commit rape when the diagnosis and treatment costs exceed the maximum compensation allowed by the state.

Inpatient, intermediate, and outpatient mental health and Substance Abuse service expenses are covered, if Medically Necessary.

Inpatient Mental Health Disorder and Substance Abuse Covered Services

Coverage includes the following 24 hour services, delivered in a psychiatric unit of a licensed general hospital; a psychiatric hospital; or a substance abuse facility; that provide evaluation and treatment for an acute psychiatric condition or substance use diagnosis, or both.

Intermediate Mental Health Disorder and Substance Abuse Covered Services

Coverage includes the following: Non-Inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient's needs. Intermediate care is based on Medical Necessity.

Outpatient Mental Health Disorder and Substance Abuse Covered Services Coverage includes the following: Services provided in person in an ambulatory care setting. Outpatient services may be provided in a licensed Hospital, a mental health or substance abuse clinic licensed by the appropriate state entity, a public community mental health center, a professional office or home-based services. Such services delivered in such offices or settings are to be rendered by a Licensed Mental Health Professional, a licensed Physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a professional clinical counselor, a clinical counselor, or a licensed nurse mental health clinical specialist acting within the scope of his/her license.

Other Covered Services for Mental Health Disorders and Substance Abuse include:

(1) Diagnosis and treatment of the following biologically based mental disorders: Schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as those terms are defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(2) For children and adolescents under age 19:

  (a) Treatment of non-biologically-based mental, behavioral, or emotional disorders that substantially interfere with or limit the functioning and social interactions of a child or adolescent. Benefits may be provided if the ongoing course of treatment is completed beyond age 19; and

  (b) Mandated benefits beyond age 19 may be covered even if coverage continues under other benefit contracts.

(3) Mental Health Disorder and/or Substance Abuse treatment provided at a Hospital or Residential Treatment Facility.

  (a) Clinically managed detoxification services in a substance abuse facility.

  (b) Partial hospitalization.

  (c) Intensive Outpatient Programs (IOP).

  (d) Day treatment.

OPIOID ANALGESICS AND EDUCATION SERVICES

Opioid Analgesics Prescribed for Chronic Pain

We pay benefits for opioid analgesic prescribed by a Physician for the treatment of chronic pain. As part of Our Utilization Review to determine coverage for opioid analgesic prescribed for the treatment of chronic pain, We will consider either or both of the following, as applicable to the case in which the opioid analgesic is prescribed:

(1) 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;

(2) 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.

The Utilization Review measures described above will not apply if the drug is prescribed under any of the following circumstances:

(1) To an individual who is a hospice patient in a hospice care program;

(2) To an individual who has been diagnosed with a terminal condition but is not a hospice patient in a hospice care program; or

(3) To an individual who has cancer, or another condition associated with the individual's cancer or history of cancer.

Opioid Education Services

Our behavioral health partner, Optum Behavioral Health, provides opioid education for Our members. When You call Us for support in opioid education, Our Member Care Team will direct You to Optum's member services team or to the Substance Use Disorder Helpline 1-855-780-5955 staffed by licensed clinician experts who will direct members to the appropriate resources.

Optum also provides comprehensive online education material for Our members related to substance use disorder. Please visit the following website for more information:https://www.liveandworkwell.com.

ORALLY ADMINISTERED CANCER MEDICATION

We pay benefits for orally administered cancer medication. The Benefit Amount for this Covered Service will be equal to or better than intravenously administered or injected cancer medications that are covered as a Covered Service under this Plan.

OUTPATIENT MEDICAL COVERAGE

We pay benefits for Outpatient medical services. Covered Services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by Us. Other Covered Services include:

(1) Professional services obtained from a Medical Practitioner, whether from a Primary Care Physician or from a Specialty Physician, and whether provided in the Physician's office or Your home.

(2) Home visits for medical care and consultations performed in Your home to examine, diagnose, and treat an illness or injury.

(3) Genetic blood tests.

(4) Immunizations to prevent respiratory syncytial virus (RSV).

(5) Surgery in a Physician's office or at an Outpatient Surgical Facility, including supplies and services provided by an assistant surgeon.

(6) Administration of an anesthetic for outpatient Surgery.

(7) Oxygen and its administration.

(8) The following types of tissue Transplants:

- (a) Cornea transplants.
- (b) Artery or vein grafts.
- (c) Prosthetic tissue replacement, including joint replacements.
- (d) Implantable prosthetic lenses, in connection with cataracts.

(9) Family Planning for certain professional Physician contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.

(10) Cochlear implants.

(11) Treatment received outside the United States, including for a medical Emergency while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for the entire period of travel including the first 90 days.

(12) Cytologic screening for the presence of cervical cancer.

OUTPATIENT PRESCRIPTION DRUG COVERAGE

We pay benefits for Medically Necessary Outpatient Prescription Drugs. Covered Services are limited to charges from a pharmacy licensed by a state within the United States for:

(1) A Prescription Drug, including for the treatment of biologically based mental illnesses on the same terms and conditions as any other disease or disorder.
(2) Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a Physician.
(3) Prescription Drugs filled by a pharmacy licensed by a state within the United States.

The appropriate drug choice for a Covered Person is a determination is best made by the Covered Person and his or her Physician. This Plan does not use a Prescription Drug Formulary.

Off-Label Drugs

Coverage will be provided for any other use of a drug approved by the FDA when the drug has not been approved by the FDA for the treatment of the particular indication for which the drug has been prescribed, provided 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 under 42 U.S.C. 1395x(t)(2), or in medical literature that meets the criteria specified below.

Medical literature may be accepted only if all of the following apply:

(1) Two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, 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, based on scientific or medical criteria, 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; and
(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 pursuant to section 1861(t)(2)(B) of the "Social Security Act," 107 Stat. 591 (1993), 42 U.S.C. 1395x(t)(2)(B), as amended, as acceptable peer-reviewed medical literature.

This benefit shall not be construed to:

(1) Require coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
(2) Require coverage for experimental drugs not approved for any indication by the FDA;
(3) Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the FDA; and
(4) Prohibit Your Policy from limiting or excluding coverage of a drug, provided that the decision to limit or exclude coverage of the drug is not based primarily on the coverage of drugs required by this section.

Exclusions and Limitations to Outpatient Prescription Drug Coverage

No benefits will be payable under this benefit subsection for services provided or expenses incurred for:

(1) Medication that is to be taken by the Covered Person, in whole or in part, at the time and place where it is dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Provider. This does not apply to drugs used in conjunction with a diagnostic service, with chemotherapy performed in the office, or drugs eligible for coverage as a medical supply.

(2) A refill dispensed more than 12 months from the date of a Prescription Order.

(3) Medication that is primarily for weight loss.

(4) More than the predetermined Managed Drug Limitations assigned to certain drugs or classification of drugs.

(5) A Prescription Order that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent. This exclusion does not apply to over-the-counter products that We must cover under Federal law with a Prescription Order.

(6) Drugs labeled "Caution - limited by Federal law to investigational use" or for investigational or experimental drugs.

(7) Prescription Drug that contains (an) active ingredient(s) that is/are:

  (a) Available in and therapeutically equivalent to another covered Prescription Drug; or

  (b) A modified version of and therapeutically equivalent to another covered Prescription Drug.

(8) Prescription Drugs for any Covered Person who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription Drug coverage may not be reinstated at a later date.

(9) Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.

(10) Fertility drugs.

(11) Drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products (except for FDA-approved smoking cessation medications required to be covered by Federal or state law as PREVENTIVE CARE COVERAGE as described in this Policy).

(12) Compound drugs unless there is at least one ingredient that requires a Prescription Order.

(13) Charges for the administration of any Prescription Drug, unless You bring Your prescribed medication to an Office Visit.

(14) 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.

(15) Oral immunizations and biologicals, although they are Federal legend Prescription 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.

(16) Any drug obtained through mail-order from a pharmacy not licensed by a state within the United States.

PEDIATRIC ORAL COVERAGE

We pay benefits for pediatric oral treatments and devices. Covered Services in this benefit subsection include the following for a Covered Person up to the age of 19. These dental benefits only apply to Covered Persons until the end of the month in which the Covered Person turns nineteen (19) years of age:

(1) Diagnostic, preventive and restorative care;
(2) Oral surgery and reconstruction;
(3) Endodontic and periodontic care;
(4) Crown and fixed bridge;
(5) Removable prosthetics; and
(6) Medically Necessary orthodontia.

Limitations to Pediatric Oral Coverage

(1) One diagnostic exam every six months, beginning before age one.
(2) Bitewing x-rays once every six months.
(3) Panoramic x-rays once every sixty months.
(4) Prophylaxis every six months beginning at age six months.
(5) Fluoride two times in a twelve-month period; three times in a twelve-month period during orthodontic treatment; sealant once every three years for occlusal surfaces only; oral hygiene instruction two times in twelve months for ages eight and under if not billed on the same day as a prophylaxis treatment.
(6) Palliative treatment of dental pain-minor procedure.
(7) Frenulectomy or frenuloplasty.
(8) Root canals on baby primary posterior teeth only; Root canals on permanent anterior, bicuspid and molar teeth, excluding teeth 1, 16, 17 and 32.
(9) Periodontal scaling and root planing once per quadrant in a two-year period.
(10) Periodontal maintenance once per quadrant in a twelve-month period.
(11) Stainless steel crowns for permanent posterior teeth one crown per tooth every 60 months.
(12) Metal/porcelain crowns and porcelain crowns limited to one crown per tooth every 60 months.
(13) Space maintainers and re-cementation of space maintainers.
(14) One resin based partial denture, replaced once within a three-year period.
(15) One complete denture upper and lower, and one replacement denture in a 36 month period after the initial installation.
(16) Prosthodontic services are limited to one every 60 months.
(17) Rebasing and relining of complete or partial dentures once in a three-year period, if performed at least six months from the seating date.

PEDIATRIC VISION COVERAGE

We pay benefits for pediatric vision treatment and devices. Covered Services in this benefit subsection include the following for a Covered Person up to the age of 19 years. These vision benefits only apply to Covered Persons until the end of the month in which the Covered Person turns nineteen (19) years of age:

(1) Routine vision screening, including dilation and with refraction every Calendar Year;

(2) One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular), and lens enhancements including standard polycarbonate lenses, blended segment lenses, intermediate vision lenses, scratch resistant coating, antireflective coating, UV coating, photochromic or tinted lenses, and standard or premium progressives, or a supply of contacts every Calendar Year;

(3) One pair of frames every Calendar Year; and

(4) Low vision optical devices including low vision services, training, and instruction to maximize the Covered Person's remaining usable vision.

Exclusions to Pediatric Vision Coverage

No benefits will be payable under this benefit subsection for services provided or expenses incurred for:

(1) Visual therapy.

(2) Two pair of glasses as a substitute for bifocals.

(3) Replacement of lost or stolen eyewear.

(4) Any vision services, treatment or material not specifically listed as a Covered Service either in this subsection or in VISION SERVICES COVERAGE.

PREVENTIVE CARE COVERAGE

We pay benefits for Preventive Care. Covered Services for Preventive Care include the services incurred by a Covered Person for the preventive health services described below if appropriate for that Covered Person in accordance with the corresponding recommendations and guidelines:

(1) Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. Examples of these services are screenings for cervical cancer and mammography.

(2) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.

(3) Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.

(4) Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.

A list of preventive services can be found at https://www.healthcare.gov/coverage/preventive-care-benefits/

Preventive Care for Adults:

(1) Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked.

(2) Alcohol misuse screening and counseling.

(3) Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk.

(4) Blood pressure screening.

(5) Cholesterol screening for adults of certain ages or at higher risk.

(6) Colorectal cancer screening for adults 50 to 75 years.

(7) Depression screening.

(8) Type 2 diabetes screening for adults 40 to 70 years who are overweight or obese.

(9) Diet counseling for adults at higher risk for chronic disease.

(10) Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting.

(11) Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and US-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.

(12) Hepatitis C screening for adults at increased risk, and one time for anyone born 1945-1965.

(13) HIV screening for everyone ages 15 to 65 years, and other ages at increased risk.

(14) Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:

- (a) Hepatitis A
- (b) Hepatitis B
- (c) Herpes Zoster
- (d) Human Papillomavirus (HPV)
- (e) Influenza (flu shot)
- (f) Measles, Mumps, Rubella
- (g) Meningococcal
- (h) Pneumococcal
- (i) Tetanus, Diphtheria, Pertussis
- (j) Varicella(chickenpox)
- (k) Qualifying coronavirus preventive service that is intended to prevent or mitigate COVID-19.

(15) Lung cancer screening for adults 55 to 80 years at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years.

(16) Obesity screening and counseling.

(17) Sexually transmitted infection (STI) prevention counseling for adults at higher risk.

(18) Statin prevention medication for adults 40 to 75 years at high risk.

(19) Syphilis screening for adults at higher risk.

(20) Tobacco use screening for all adults and cessation interventions for tobacco users, including a 90-day supply of FDA-approved smoking cessation medications when prescribed by a health care provider.

(21) Tuberculosis screening for certain adults without symptoms at high risk.

Preventive Care for Women, Including Pregnant Women:

(1) Anemia screening on a routine basis.

(2) Breastfeeding comprehensive support and counseling from trained providers. Access to breastfeeding supplies, including the cost of renting or the purchase of one (1) breast pump per Calendar Year, for pregnant and nursing women.

(3) Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling as prescribed by a health care provider for women with reproductive capacity, not including abortifacient drugs.

(4) Folic acid supplements for women who may become pregnant.

(5) Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.

(6) Gonorrhea screening for all women at higher risk.

(7) Hepatitis B screening for pregnant women at their first prenatal visit.

(8) Preeclampsia prevention and screening for pregnant woman with high blood pressure.

(9) Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.

(10) Syphilis screening for all pregnant women and women at increased risk.

(11) Tobacco use screening and interventions for all women and expanded tobacco intervention and screening for pregnant tobacco users.

(12) Urinary tract or other infection screening for pregnant women.

(13) Breast cancer generic testing (BRCA) for women at higher risk.

(14) Screening Mammography to detect the presence of breast cancer in adult women, as follows:

(a) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(b) If a woman is at least forty years of age but under fifty years of age, either of the following:

(i) One screening mammography every two years;

(ii) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year;

(c) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

(15) Breast cancer chemoprevention counseling for women at higher risk.

(16) Cervical cancer screening, including:

(a) Pap test (also called Pap smear) every 3 years for women 21 to 65 years.

(b) Human Papillomavirus (HPV) DNA Test with the combination of a Pap smear every 5 years for women 30 to 65 years who don't want a Pap smear every 3 years.

(17) Chlamydia infection screening for younger women and other women at higher risk.

(18) Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with Type 2 diabetes before.

(19) Domestic and interpersonal violence screening and counseling for all women.

(20) Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women.

(21) Osteoporosis screening for women over age 60 years depending on risk factors.

(22) Sexually transmitted infection (STI) counseling for sexually active women.

(23) Urinary incontinence screening for women yearly.

(24) Well-woman visits to obtain recommended services for women under 65 years.

Preventive Care for Children:

(1) Alcohol, tobacco, and drug use assessments for adolescents.

(2) Autism screening for children at 18 and 24 months.

(3) Behavioral assessments for children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10; years, 11 to 14 years, 15 to 17 years.

(4) Bilirubin concentration screening for newborns.

(5) Blood Pressure screening for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;

(6) Blood screening for newborns.

(7) Cervical dysplasia screening for sexually active females.

(8) Depression screening for adolescents beginning routinely at age 12 years.

(9) Developmental screening for children under age 3 years, and surveillance throughout childhood.

(10) Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders. Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

(11) Fluoride chemoprevention supplements for children without fluoride in their water source.

(12) Fluoride varnish for all infants and children as soon as teeth present.

(13) Gonorrhea preventive medication for the eyes of all newborns.

(14) Hearing screening for all newborns; once for children between 11 and 14 years; once between 15 and 17 years; and once between 18 and 21 years.

(15) Height, weight and body mass index (BMI) measurements for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

(16) Hematocrit or Hemoglobin screening for all children.

(17) Hemoglobinopathies or sickle cell screening for newborns.

(18) Hepatitis B screening for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and US-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11-17 years.

(19) HIV screening for adolescents at higher risk.

(20) Hypothyroidism screening for newborns;

(21) Immunization vaccines for children from birth to age 18 years —doses, recommended ages, and recommended populations vary:

- (a) Diphtheria, Tetanus, Pertussis;
- (b) Haemophilus influenzae type b;
- (c) Hepatitis A;
- (d) Hepatitis B;
- (e) Human Papillomavirus (HPV); (f) Inactivated Poliovirus;
- (f) Influenza (flu shot);
- (g) Measles;
- (h) Meningococcal;
- (i) Pneumococcal;
- (j) Rotavirus;
- (k) Varicella;
- (l) coronavirus preventive service that is intended to prevent or mitigate COVID-19.

(22) Iron supplements for children ages 6 to 12 months at risk for anemia.

(23) Lead screening for children at risk of exposure.

(24) Maternal depression screening for mothers of infants at 1, 2, 4, and 6- month visits.

(25) Medical history for all children throughout development. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

(26) Obesity screening and counseling.

(27) Oral health risk assessment for young children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.

(28) Phenylketonuria (PKU) screening for this genetic disorder in newborns.

(29) Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk;

(30) Tuberculin testing for children at higher risk of tuberculosis. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

(31) Vision screening for all children.

Benefits for Preventive Care Covered Services listed in this provision are exempt from any Deductibles under the Policy. If Preventive Care recommendations set forth above do not specify the frequency, method, treatment or setting for the provision of a service, We may use reasonable medical management techniques to determine coverage limitations. See **MEMBER CARE, Section 3**, for information regarding using Our Benefit Card to access preventive health services without a Deductible.

Benefits for Covered Services for Preventive Care and chronic disease management benefits may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value preventive services.

As new recommendations and guidelines are issued, those services will be considered Preventive Care Covered Service Expenses when required by the United States Secretary of Health and Human Services.

Age or frequency limits on a Preventive Care Covered Service does not equate to an exclusion of that Covered Service when Medically Necessary or required under state law for individuals who fall outside the Preventive Services guidelines.

PROSTHETIC DEVICE COVERAGE

We pay benefits for Prosthetic Devices. Covered Services include:

(1) The purchase, fitting, needed adjustment, repairs, and replacements of Prosthetic Devices that:
   (a) Replace all or part of a missing body part and its adjoining tissues; or
   (b) Replace all or part of the function of a permanently useless or malfunctioning body part.

(2) Intraocular lens implantation for the treatment of cataracts or aphakia.

(3) Artificial larynx, breast prosthesis, or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the Covered Person and the previous Prosthetic Device cannot be modified).

(4) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).

Limitations to Prosthetic Device Coverage

If more than one Prosthetic Device can meet a Covered Person's functional needs, only the charge for the most cost-effective Prosthetic Device will be considered a Covered Service Expense.

Exclusions to Prosthetic Device Coverage

No benefits will be paid for:

(1) Dentures.

(2) Replacing teeth or structures directly supporting teeth.
(3) Dental appliances.
(4) Non-rigid appliances such as elastic stockings, garter belts, arch supports and corsets.
(5) Artificial heart transplants.
(6) Wigs (except following cancer treatment).
(7) Penile prosthesis in men suffering impotency resulting from disease or injury.

RADIATION COVERAGE

We pay benefits for radiation therapy and treatment.

RECONSTRUCTIVE SURGERY COVERAGE

We pay benefits for Reconstructive Surgery. Covered Services include:

(1) Reconstructive Surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury, or an earlier treatment to create a more normal appearance.
(2) Reconstructive breast surgery services as a result of a partial or total Medically Necessary mastectomy. Coverage includes Surgery and reconstruction of the diseased and non-diseased breast and Prosthetic Devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.

Exclusions to Reconstructive Surgery Coverage

No benefits will be paid for Reconstructive Surgery needed as a result of an earlier treatment unless the first treatment would have been a Covered Service under the Plan. Coverage for Reconstructive Surgery does not apply to orthognathic surgery.

REHABILITATION AND SKILLED NURSING FACILITY COVERAGE

We pay benefits for Rehabilitation and Skilled Nursing Facility services, subject to the following limitations:

(1) Covered Services available to a Covered Person while confined primarily to receive Rehabilitation are limited to those specified in this provision.
(2) Covered Services rendered by Rehabilitation Medical Practitioners, social worker or psychologist on an Inpatient or outpatient basis.
(3) Covered Service Expenses for Provider Facility services are limited to charges made by a Hospital, Rehabilitation Facility, or Skilled Nursing Facility for:
    (a) Daily room and board and nursing services.
    (b) Physical medicine therapy services.
    (c) Diagnostic testing.
    (d) Drugs and medicines that are prescribed by a Physician, must be filled by a licensed pharmacist, and are approved by the FDA.
(4) Covered Services for confinement in a Skilled Nursing Facility is limited to 90 days per Calendar Year.
(5) Covered Service Expenses for non-Provider Facility services are limited to the professional services of Rehabilitation Medical Practitioners.

Covered Rehabilitation Services at a Rehabilitation or Skilled Nursing Facility, or at locations described below, include physical medicine therapy services as follows:

(1) 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. Physical therapy Covered Services are limited as set forth in Your Schedule of Benefits when rendered as Physician Home Visits (see Definitions), Office Visit services, or Outpatient Services. When rendered in the home by a Home Health Agency, Home Health Care Coverage limits apply.

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.

(2) Speech therapy for the correction of a speech impediment. Speech therapy Covered Services are limited as set forth in Your Schedule of Benefits when rendered as Physician Home Visits, Office Visit services, or Outpatient services. When rendered in the home, Home Health Care Services limits apply.

(3) 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 Covered Services are limited as set forth in Your Schedule of Benefits when rendered as Physician Home Visits, Office Visit services, or Outpatient services. When rendered in the home by a Home Health Agency, Home Health Care Coverage limits apply.

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; 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.

(4) Chiropractic Care/Manipulation Therapy includes chiropractic/osteopathic 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 counted toward any maximum for Chiropractic Care/Manipulation Therapy services as specified in the Schedule of Benefits. Chiropractic Care/Manipulation Therapy Covered Services are limited as set forth in Your Schedule of Benefits.

Chiropractic Care/Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

(5) Cardiac Rehabilitation to restore an individual's functional status after a cardiac event is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Cardiac rehabilitation Covered Services are limited as set forth in Your Schedule of Benefits when rendered as Physician Home Visits, Office Visit services, or Outpatient services. When rendered in the home by a Home Health Agency, Home Health Care Coverage limits apply.

Home programs, on-going conditioning and maintenance are not covered.

(6) Pulmonary Rehabilitation to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to outpatient short-term respiratory services for conditions expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Pulmonary rehabilitation Covered Service are limited as set forth in Your Schedule of Benefits when rendered as Physician Home Visits, Office Visit services, or Outpatient services. When rendered in the home by a Home Health Agency, Home Health Care Coverage limits apply.

Care ceases to be Rehabilitation upon Our determination of any of the following:

(1) Further treatment cannot restore bodily function beyond the level the Covered Person already possesses.
(2) There is no measurable progress toward documented goals.
(3) Care is primarily Custodial Care.

Limitations to Rehabilitation and Skilled Nursing Facility Coverage

See the Schedule of Benefits for benefit levels or additional limits for expenses related to Rehabilitation and Skilled Nursing Facility Coverage.

SURGICAL SERVICES

Coverage for Surgical Services when provided as part of Physician home visits and office services, Inpatient services, or outpatient services includes but is not limited to:

(1) Performance of accepted operative and other invasive procedures.
(2) The correction of fractures and dislocations.
(3) Anesthesia and surgical assistance when Medically Necessary.
(4) Usual and related pre-operative and post-operative care.
(5) Other procedures as approved by Us.

The surgical fee includes normal post-operative care, also known as the “global period.” We may combine the Benefit Amount payable 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:

(1) Operative and cutting procedures.
(2) Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
(3) Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

TELEMEDICINE COVERAGE

We pay benefits for Covered Services offered through Telemedicine if the Covered Service would be covered when provided through in-person consultation between a Covered Person and a Provider. We will not exclude coverage for Covered Services solely because they were provided through Telemedicine. Providers offering Telemedicine services must be appropriately licensed in the state of Ohio.

TEMPOROMANDIBULAR JOINT DISORDER COVERAGE

We pay benefits for the treatment of temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

We pay benefits for orthognathic (jawbone) surgery for a medical condition or injury which improves function of the joint or bone that is Medically Necessary to gain functional capacity of the joint or bone.

TRANSPLANT COVERAGE

We pay benefits for Transplant services. If We determine a Covered Person is an appropriate candidate for a Transplant, Covered Services include:

(1) Pre-Transplant evaluation.
(2) Unrelated donor searches for bone marrow/stem cell Transplants for a covered Transplant procedure, as approved by Us, up to a $30,000 limit per Transplant.
(3) Pre-Transplant harvesting.
(4) Pre-Transplant stabilization, meaning an Inpatient stay to medically stabilize a Covered Person to prepare for a later Transplant, whether the Transplant occurs.
(5) High dose chemotherapy.
(6) Peripheral stem cell collection.
(7) The Transplant itself.
(8) Post-Transplant follow-up.
(9) Reasonable and necessary travel expenses as determined by Us when You are required to travel more than 75 miles from Your residence to reach the facility where Your Transplant 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 Covered Person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions.

Transplant Donor Expenses

We pay benefits for Covered Services incurred by a live donor if benefits are not available to the donor from any other source. If benefits are payable, We will pay benefits for Covered Services incurred by a live donor as if they were Covered Services of the Covered Person if:

(1) They would otherwise be considered Covered Services under the Policy;
(2) The Covered Person received an organ or bone marrow of the live donor; and
(3) The Transplant is Medically Necessary.

Limitations to Transplant Coverage

In addition to the exclusions and limitations specified elsewhere in this section:

(1) Covered Service Expenses for a Transplant will be limited to a maximum for all expenses associated with the Transplant.
(2) Coverage for travel expenses (transportation and lodging) related to a Transplant is limited to $10,000 per Transplant.
(3) Non-Covered Services for transportation and lodging include, but are not limited to:
    (a) Childcare;
    (b) Mileage within the medical transplant facility city;

(c) Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us;
(d) Frequent Flyer miles;
(e) Coupons, Vouchers, or Travel tickets;
(f) Prepayments or deposits;
(g) Services for a condition that is not directly related, or a direct result, of the Transplant;
(h) Telephone calls;
(i) Laundry;
(j) Postage;
(k) Entertainment;
(l) Interim visits to a medical care facility while waiting for the actual transplant procedure;
(m) Travel expenses for donor companion/caregiver;
(n) Return visits for the donor for a treatment of a condition found during the evaluation;

Exclusions to Transplant Coverage

No benefits will be provided or paid under this Transplant coverage:

(1) For search and testing to locate a suitable donor except as expressly provided for in this provision.
(2) Transplants that are considered experimental, unproven or investigational.
(3) Living donor travel expenses, unless expressly provided for in this provision.
(4) Non-human organs or tissue (xenograft) obtained from another species or artificial organs, and the related implantation services.
(5) Collection and/or storage of blood products to include stem cells for any unscheduled medical procedure, or non-covered medical procedures.
(6) For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
(7) To keep a donor alive for the Transplant operation.
(8) For purchase of the organ or tissue, unless expressly provided for in this provision.

URGENT CARE CENTER COVERAGE

We pay benefits for all Covered Services obtained at Urgent Care Centers.

If You experience an accidental injury or a medical problem, We will determine whether Your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on Your symptoms. 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. 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 Care medical problem and Your Physician authorizes You to go to an emergency room, Your care will be paid at the level specified for Emergency Services.

VISION SERVICES COVERAGE

Benefits are available for medical and surgical treatment of injuries and/or diseases affecting the eye. Vision screenings required by federal law are covered under PREVENTIVE CARE COVERAGE. Benefits for other Covered Services are based on the setting in which services are received.

Benefits are not available for glasses and contact lenses except as described in DURABLE MEDICAL EQUIPMENT COVERAGE. Additional Covered Services include:

(1) Determination of refraction;
(2) Routine Ophthalmological examination including refraction for new and established patients; and
(3) A visual functional screening for visual acuity.

These additional services are not part of PREVENTIVE CARE COVERAGE and will be based on the setting at which services are received. No additional ophthalmological services are covered, except as described above.

SECTION 6 – GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be provided or paid for:

(1) Any service or supply provided without cost to the Covered Person.

(2) Expenses/surcharges imposed on the Covered Person by a Provider (including a Hospital) but that are actually the responsibility of the Provider to pay.

(3) Any services performed by a member of a Covered Person's Immediate Family or the Covered Person him/herself.

(4) Any services not identified and included as Covered Services under the Policy. You will be fully responsible for payment for any services that are not Covered Services.

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

(1) Administered or ordered by a Physician; and

(2) Medically Necessary to the diagnosis or treatment of an injury or illness, or covered under the PREVENTIVE CARE COVERAGE provision in this Policy.

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

(1) For services or supplies that are provided prior to the Effective Date or after the termination date of this Policy, except as expressly provided for under the Benefits After Coverage Terminates clause in **TERMINATION, Section 11**.

(2) For any portion of the charges that are in excess of the eligible Benefit Amount for the Covered Service.

(3) For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass Surgery. This exclusion does not apply to myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

(4) For breast reduction unless Medically Necessary.

(5) For breast augmentation except as part of breast reconstruction after a Medically Necessary mastectomy or Medically Necessary lumpectomy or in repair of breast asymmetry due to a Medically necessary mastectomy or Medically Necessary lumpectomy that results in a significant deformity.

(6) For modification of the physical body to improve the psychological, mental, or emotional well-being of the Covered Person, such as sex-change Surgery or sex transformation and/or reversal thereof. This exclusion includes sexual therapy and counseling.

(7) For the reversal of voluntarily induced sterilization and vasectomies.

(8) For abortion (unless the life of the mother would be endangered if the fetus were carried to term or in the case of rape or incest).

(9) Services and supplies 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 protheses 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.

(10) For expenses for television, telephone, or expenses for other persons.

(11) For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.

(12) For telephone consultations (that do not constitute Telemedicine) or for missed, cancelled or failure to keep a scheduled appointment.

(13) For Hospital room and board and nursing services for the first Friday or Saturday of an Inpatient stay that begins on one of those days, unless it is an Emergency, or Medically Necessary Inpatient Surgery is scheduled for the day after the date of admission.

(14) For Hospital room and board and nursing services for pre-surgical services, unless Medically Necessary.

(15) For stand-by availability of a Medical Practitioner, including one-time or monthly fees paid to retain concierge-type Medical Practitioners, when no treatment is rendered.

(16) For Dental Services, including braces for any medical or dental condition, Surgery and treatment for oral Surgery, except as expressly provided for under the DENTAL SERVICE COVERAGE provision in this Policy.

(17) For Cosmetic Treatment, except for Reconstructive Surgery that is incidental to or follows Surgery or an injury covered under this Policy or performed to correct a birth defect.

(18) For diagnosis or treatment of learning disabilities.

(19) For eye refractive Surgery, when the primary purpose is to correct nearsightedness, farsightedness, aging eye, or astigmatism.

(20) Custodial Care, convalescent care or rest cures.

(21) 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.

(22) For vocational, educational, or recreational therapy, vocational Rehabilitation, outpatient speech therapy, or occupational therapy, except as expressly provided for in this Policy.

(23) For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, and similar programs.

(24) For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this Policy.

(25) For Experimental or Investigational Treatment(s) or unproven services. The fact that an Experimental or Investigational Treatment or unproven service is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an Experimental or Investigational Treatment or unproven service for the treatment of that particular condition.

(26) As a result of an injury or illness arising out of, or in the course of, employment for wage or profit, if the Covered Person is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If You enter a settlement that waives a Covered Person's right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event the workers' compensation insurance carrier denies coverage for a Covered Person's workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.

(27) As a result of:

- (a) An injury or illness caused while serving in the armed forces, including as a result of any act of declared or undeclared war.
- (b) The Covered Person taking part in a riot, civil disobedience, terrorist attack, nuclear explosion, or nuclear accident.

(28) For any services or supplies provided to a person who is not a Covered Person in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

(29) For or related to treatment of hyperhidrosis (excessive sweating).

(30) For surgical treatment of gynecomastia.

(31) For treatment of onychomycosis.

(32) For refills of lost or stolen medications.

(33) Except as specifically identified as a Covered Service under the Policy, services or expenses for alternative or complementary treatments, including without limitation: acupressure, acupuncture, holistic medicine, homeopathy, aroma therapy, hypnotism, 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, neurofeedback, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

(34) For Prescription Drugs for any Covered Person who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription Drug coverage may not be reinstated at a later date.

(35) For the following miscellaneous items: biofeedback; blood and blood products; care or complications resulting from non-Covered Services; chelating agents; domiciliary care; food and food supplements (except where required by federal or state law); routine foot care, over-the-counter foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-Covered Person biological parent; nutrition or dietary supplements (except where required by Federal or state law as PREVENTIVE CARE COVERAGE); pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; sclerotherapy for varicose veins; endovascular laser procedures; treatment of spider veins; smoking cessation drugs, programs or services (except for smoking cessation interventions required to be covered by Federal or state law as PREVENTIVE CARE COVERAGE as described in this Policy); transportation expenses, unless specifically described in this Policy.

(36) For court ordered testing or care unless Medically Necessary.

(37) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Covered Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

(38) 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.

(39) Wilderness camps.

(40) Services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether You assert Your rights to obtain this coverage or payment of these services.

(41) 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:

- (a) Transplant preparation.
- (b) Initiation of immunosuppressives.
- (c) Direct treatment of acute traumatic injury, cancer, or cleft palate.

(42) Services to test aptitude, ability, intelligence or interest.

(43) Services for educational purposes.

(44) 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 does not result in any additional improvement.

(45) For the following:

- (a) Physician or Medical Practitioners' charges for consulting with a Covered Person by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to- face) care with a Covered Person except as otherwise described in this Policy.
- (b) Charges for furnishing and/or receiving medical records and reports.
- (c) Charges for doing research with Providers not directly responsible for Your care.
- (d) Charges that are not documented in Provider records.
- (e) 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.
- (f) 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, or “no-show” fees charged by Your Medical Practitioner for missing an appointment.

(46) Weight loss programs, whether or not 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.

(47) For self-help training and other forms of non-medical self-care, except as otherwise provided in this Policy.

(48) For services related to applied behavior analysis except as otherwise provided in this Policy for the children ages 0 to 21 with a medical diagnosis of Autism Spectrum Disorder.

(49) In vitro fertilization, artificial insemination (except where required by federal or state law), ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures (except where required by federal or state law).

SECTION 7 – DEPENDENT COVERAGE

DEPENDENT ELIGIBILITY

Your Dependents become eligible for coverage under this Policy on the latter of:

(1) The date You became insured under this Policy; or

(2) The first day of the Premium period/first full calendar month after the date of becoming Your Dependent.

EFFECTIVE DATE FOR INITIAL DEPENDENTS

The Effective Date for Your initial Dependents, if any, is shown on the Schedule of Benefits. Only Dependent(s) included in the application for this Policy will be covered on Your Effective Date.

ADDING A NEWBORN CHILD

An Eligible Child born to a Subscriber or Spouse will be covered, at no additional cost, from the time of birth until the 31st day after its birth. The newborn child will be covered from the time of its birth for Loss due to injury and illness, including Loss from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional Premium will be required to continue coverage beyond the 31st day after the date of birth of the child. Coverage of the child will terminate on the 31st day after its birth unless We have received both:

(1) Written notice of the child's birth and Your intent to enroll the Eligible Child as a new Dependent on Your Policy, before the 31st day after their birth; and

(2) The required Premium within 90 days of the child's birth.

If We do not receive the required accumulated Premium payment(s) within 90 days of the child's birth, the child's coverage will be terminated retrospectively to the day after the 31st day after their birth.

ADDING AN ADOPTED CHILD

An Eligible Child legally placed for adoption with a Subscriber or Spouse will be covered, at no additional cost, from the date of placement until the earlier of (a) the 31st day after placement or (b) the date placement is terminated. The child will be covered from the date of placement for Loss due to injury and illness, including Medically Necessary care and treatment of conditions existing prior to the date of placement.

Additional Premium will be required to continue coverage beyond the 31st day following placement of the child. Coverage of the child will terminate on the 31st day following placement, unless We have received both:

(1) Written notice of the Covered Person's intent to adopt the child; and

(2) Any additional Premium required for the addition of the child within 90 days of the date of placement.

If We do not receive the required accumulated Premium payment(s) within 90 days of the child's placement, the child's coverage will be terminated retrospectively to the day after the 31st day after their placement.

As used in this provision, "placement" means the assumption and retention by a Covered Person for total or partial support of the child in anticipation of the adoption of the child.

ADDING OTHER DEPENDENTS

If You apply in writing for coverage of a Dependent and You pay the required Premiums, the Effective Date will be shown in the written notice to You that the Dependent is insured under this Policy. See "Special Enrollment Periods" in the following section for more information about adding other Dependents.

SECTION 8 – ONGOING ELIGIBILITY & SPECIAL ENROLLMENT PERIODS

ONGOING ELIGIBILITY FOR ALL COVERED PERSONS

A Covered Person's eligibility for coverage under this Policy will cease on the earlier of:

(1) The date a Covered Person accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the Premium for coverage under this Policy; or

(2) The date a Covered Person's employer and a Covered Person treat this Policy as part of an employer-provided health plan for any purpose, including tax purposes.

ONGOING ELIGIBILITY FOR DEPENDENTS

A Dependent will cease to be a Covered Person at the end of the Premium period in which he or she ceases to be Your Spouse due to divorce, or if a child, ceases to be an Eligible Child.

An Eligible Child ceases to be a Dependent upon their 26th birthday. Coverage may be extended to the Eligible Child's 28th birthday if all of the following are true:

(1) The child is the natural child, stepchild, or adopted child of a Covered Person;

(2) The child is a resident of this state or a full-time student at an accredited public or private institution of higher education;

(3) The child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and

(4) Is not eligible for coverage under Medicaid or Medicare.

We must **receive** notification within 90 days of the date a Dependent ceases to be an Eligible Dependent. If notice is received by Us more than 90 days from this date, any unearned Premium will be credited only from the first day of the Policy/calendar month in which We receive the notice.

A Covered Person will not cease to be a Dependent Eligible Child solely because of age if the Eligible Child is:

(1) Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and

(2) Mainly dependent on You for support.

OPEN ENROLLMENT

You may enroll under this Plan during an open enrollment period that runs from November 1 through January 15 each year. Individuals who enroll through December 15 will have an Effective Date of coverage on January 1 of the following Calendar Year, and individuals who enroll between December 16 and January 15 will have an Effective Date of February 1 of the Plan Year. No Policy is effective unless the first Premium payment is received before the Effective Date.

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.

SPECIAL ENROLLMENT PERIODS — QUALIFYING LIFE EVENTS

If You experience a Triggering Event (as explained below), You may qualify for a special enrollment period, during which You may enroll for coverage and enroll Your eligible Dependent(s), instead of waiting for the next annual open enrollment period.

Triggering Events for a special enrollment period can be categorized into the following groups:

(1) Loss of qualifying health coverage;
(2) Change in household size;
(3) Change in primary place of living;
(4) Change in eligibility for Health Insurance Marketplace (or "Exchange") coverage or help paying for coverage;
(5) Enrollment or plan error;
(6) Other qualifying changes; and
(7) Maintaining status as a member of a Federally-recognized tribe or a shareholder in an Alaska Native Corporation (which Triggering Event can only be used one time per month).

Note that failure to pay Premiums, or coverage that is terminated or rescinded on the basis of fraud or an intentional misrepresentation of material fact is never considered a Triggering Event.

(1) Loss of qualifying health coverage" includes:
    (a) You or Your Dependent lost Minimum Essential Coverage during or at the end of the coverage year, including but not limited to Medicaid, CHIP, qualifying employer sponsored coverage;
    (b) It is the end of the plan year for Your non-Calendar Year employer-sponsored coverage;
    (c) Your exhausted Your COBRA coverage ;
    (d) You are no longer eligible to be covered as a dependent due to reaching the limiting age;
    (e) You or Your Dependent loses employer-sponsored health plan coverage because of voluntary or involuntary termination of employment or a reduction in work hours, for reasons other than misconduct; or
    (f) You, Your Spouse or Eligible Child loses coverage under an employer- sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, or death of the covered employee.

(2) "Change in household size" includes:
    (a) You gain a Dependent or become a Dependent through marriage;
        i. One spouse must have had Minimum Essential Coverage for one or more days in the 60 days prior to the marriage, unless that spouse was living in a foreign country or US territory, or is a member of a Federally recognized tribe or a shareholder in an Alaska Native Corporation.
    (b) You gain a Dependent or become a Dependent through birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order.

(3) "Change in primary place of living" includes:
    (a) You or Your Dependent gain access to new plans as a result of a permanent move.
        i. You or Your Dependent must have had Minimum Essential Coverage for one or more days in the 60 days prior to the marriage, unless You or Your Dependent were living in a foreign country or US territory, or is a member of a Federally recognized tribe or a shareholder in an Alaska Native Corporation.
    (b) Moving solely for medical treatment or vacation are not valid Triggering Events.

(4) “Change in eligibility for Exchange coverage or help paying for coverage” includes:

(a) You or Your Dependent become newly eligible for Exchange coverage due to gaining status as a citizen, national, or lawfully present individual;

i. Changing from one legally present status to another is not a valid Triggering Event.

(b) You gain or maintain status as a member of a federally-recognized tribe or a shareholder in an Alaska Native Corporation;

i. This Triggering Event can only be used one time per month.

(c) You or Your Dependent is released from incarceration;

(d) You or Your Dependent are determined newly eligible or newly ineligible for advance payments of the Premium tax credit (APTC) or has a change in eligibility for cost-sharing reductions (CSR);

(e) were previously both

i. ineligible for APTC solely because of household income below 100 percent of the Federal poverty level and

ii. ineligible for Medicaid because You were living in a non-Medicaid expansion state, also known as being in the coverage gap, and then experience a change in household income or move to a new state, which results in You becoming newly eligible for APTC.

(5) “Enrollment or plan error” includes:

(a) You or Your Dependent's enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee or agent of the Exchange, or of the Department of Health and Human Services (HHS), its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities;

(b) You or Your Dependent's enrollment or non-enrollment in a plan or inaccurate eligibility determination is a result of a technical error;

(c) You or Your Dependent adequately demonstrate to the Exchange or State Regulatory Agency, that the plan in which You enrolled substantially violated a material provision of its contract in relation to the enrollee;

(d) You or Your Dependent applied for coverage through the Exchange either during the annual open enrollment period or due to a qualifying event or at the State Medicaid or CHIP agency during the annual open enrollment period, and are determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event.

(e) You or Your Dependent adequately demonstrate to the Exchange that a material error related to plan benefits, service area, or Premium influenced the enrollee's decision to purchase the plan through the Exchange.

(6) “Other qualifying changes” includes:

(a) You or Your Dependent are survivors of domestic abuse or spousal abandonment;

(b) At the option of the Exchanges, where a consumer resolves a data matching issue following the expiration of an inconsistency period or has an annual household income under 100 percent of the Federal poverty level and did not enroll in coverage while waiting for HHS to verify that he or she meets the citizenship, national, or immigration status.

(c) You or Your Dependent's enrollment or non-enrollment in a plan is the result of an exceptional circumstance, as determined by the Secretary of HHS, including being incapacitated or experiencing a natural disaster.

(d) You or Your Dependent's enrollment or non-enrollment in a plan is the result of an unforeseen event or a first-time requirement for Exchange enrollees.

(e) You or Your Dependent's, enrollment or non-enrollment in a plan is the result of a significant life event resulting in lack of access to his or her application or account and the individual, enrollee, or dependent has experienced a change in situation or status that now requires that he or she obtain Minimum Essential Coverage. This includes AmeriCorps servicemen and women who are starting or ending their service.

Triggering Events do not include loss of coverage due to failure to make Premium payments on a timely basis. This includes COBRA Premiums prior to the expiration of Your COBRA coverage and situations allowing for a rescission as specified under federal and state law.

Special enrollment periods begin on the date the Triggering Event occurs, and end on the 61st day afterwards. For "Loss of qualifying health coverage" and "Change in primary place of living" categories of Triggering Event, You may also submit an application in the 60 days leading up to the event. Persons who enroll during a special enrollment period will have their coverage Effective Dates determined as follows unless they indicated otherwise in their application for coverage:

(1) In the case of birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order, Your coverage is effective on the date of the event;

(2) In the case of marriage, or in the case where You lose Minimum Essential Coverage, coverage is effective on the first day of the following month;

(3) In the case where the application is submitted before the event, coverage is effective the first day of the month following the event.

In all other cases, the Effective Dates are as follows:

(1) For an application made between the first and the 15th day of any month, the Effective Date of coverage will be the first day of the following month; or

(2) For an application made between the 16th and the last day of the month, the Effective Date of coverage will be the first day of the second following month.

SPECIAL ENROLLMENT PERIOD FOR PREGNANT WOMEN

If You are pregnant You may enroll in coverage at any time during Your pregnancy so long as You provide Us with certification from Your Physician that You are pregnant.

Coverage will be effective the first day of the month in which You received the certification from Your Physician that You are pregnant, unless You elect coverage to be effective on the first day of the month following certification.

Premiums are 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 of Your coverage Effective Date.

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 the Exchange.

SECTION 9 – PREMIUMS & PAYMENT OBLIGATIONS

PREMIUM

Sidecar Health sets the Premiums that apply to coverage provided under this Policy. Those Premiums are shown in the Schedule of Benefits. Each Premium is based on the rate table in effect on that Premium's due date. The metal level/plan selected, age and Tobacco Use of Covered Persons, and Your place of Residence on the Premium due date are the only the factors used to determine Your Premium rates. Premiums are payable on a monthly basis.

As permitted by law, We have the right to change Premiums prior to renewal of this Policy if Your Residence changes, if You misstate Your age or misstate Your Tobacco Use on Your application. We will notify You at least 30 days in advance of taking action or making a change permitted by this clause at Your last address as shown in Our records. We will make no change in Your Premium due to claims made under this Policy by any Covered Persons or a change in a Covered Person's health.

While this Policy is in force, We will not restrict coverage already in effect.

PREMIUM PAYMENT

The first Premium payment for this Policy is due on or before Your Effective Date. Your subsequent Premium payment shall be due on the 1st or the 15th of each month based on Your Effective Date. Each Premium payment is to be paid to Us on or before the due date. Your Premium becomes overdue following the last day of the period for which the preceding Premium was paid.

GRACE PERIOD

After You make Your first Premium payment, if You fail to make a Premium payment by the due date, You will be granted a grace period of 10 days during which to make Your past-due Premium payment.

If Your Premium is not paid by the end of the grace period, Your coverage will be terminated after the last day of the grace period, **effective** the day after the last day of paid coverage. You will be responsible for any expenses incurred during the grace period, and will be billed for any expenses paid by Us during that time, if You fail to make Your past-due Premium payment.

Extended Grace Period for Covered Person(s) receiving APTC

If a Covered Person is receiving an advance payment of the premium tax credit (APTC), and has made at least one full month's premium payment during the Calendar Year, You will be provided a grace period of three (3) months. Your coverage will remain in force during the grace period. However, We will suspend payment of expenses for Covered Services during the second and third months of the grace period.

If Your past-due premium payment is not paid by the end of the three-month grace period, Your coverage will be terminated after the last day of the grace period, effective the last day of the first month of the grace period. You will be responsible for any expenses incurred during the second and third months of the grace period, and will be billed for any expenses paid by Us during that time, if You fail to make Your past-due premium payment.

If this Policy is terminated for nonpayment of Premium, and You request reinstatement, all past due and current Premium must be paid in full to be reinstated. We may decline reinstatement at Our discretion. See REINSTATEMENT below.

MISSTATEMENT OF AGE

If a Covered Person's age was misstated, We will re-determine Premium for that Covered Person according to the correct age.

There will be an equitable adjustment Premium to ensure We are paid a Premium based on the Covered Person's true age. If the change results in a lower Premium, We will refund any excess Premium. If the change results in a higher Premium, You will owe Us the additional Premium.

CHANGE OR MISSTATEMENT OF RESIDENCE

If You change Your Residence, You must notify Us of Your new Residence within 60 days of the change. Your Premium will be based on Your new Residence beginning the first Premium due date/first day of the next calendar month after the change. If Your Residence is misstated on Your application, or You fail to notify Us of a change of Residence, We will apply the correct Premium amount beginning on the first Premium due date/first day of the first full calendar month You resided at the new or corrected place of Residence. If the change results in a lower Premium, We will refund any excess Premium. If the change results in a higher Premium, You will owe Us the additional Premium.

MISSTATEMENT OF TOBACCO USE

The answer to the tobacco question on the application is a material factor in determining Your Premium. If a Covered Person's Use of Tobacco was misstated on the Covered Person's application for coverage under this Policy, We have the right to make an equitable adjustment of Premium so We will be paid the appropriate Premium based on the Covered Person's corrected Use of Tobacco, back to the original Effective Date.

BILLING/ADMINISTRATIVE FEES

Upon prior written notice, We may charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

THIRD PARTY PAYMENT OF PREMIUMS OR COST SHARING

We require each policyholder to pay his or her Premiums. Our payment policies were developed based on guidance from the Centers for Medicare and Medicaid Services (CMS) recommendations against accepting third party payment of Premiums. Consistent with CMS guidance, the following are the only acceptable third parties who may pay Premiums on Your behalf:

(1) Ryan White HIV/AIDS program under Title XXVI of the Public Health Service Act;
(2) Indian tribes, tribal organizations, or urban Indian organizations;
(3) State and Federal government programs;
(4) Dependents and family members; or
(5) 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.

Upon discovery that Premiums were paid by a person or entity other than those listed above, We will reject the payment and inform the Covered Person the payment was not accepted and the Premium remains due.

Similarly, if We determine payment was made for Deductibles or other Cost Sharing by a third party, We will treat this as third party Premium payment that may not be counted towards Your Deductible or Out-of-Pocket Maximum. For example, a drug manufacturer paying for all or part of a medication.

SECTION 10 - SWIPE LIMITS & PRE-APPROVAL OF BENEFIT CARD TRANSACTIONS

PRE-APPROVAL FOR CERTAIN BENEFIT CARD TRANSACTIONS

The Benefit Card can be used to pay for Covered Services at the point-of-service or point-of-care, up to the Swipe Limit. There are different Swipe Limits depending on whether You are in a Medical Practitioner's office or a Pharmacy.

To use the Benefit Card to pay for a Covered Service Expense that exceeds the Swipe Limit, You must obtain Our prior approval to increase the Swipe Limit for such transaction. To request pre-approval, submit to Us a Provider's Pre-Bill or such other evidence that is equivalent to a Medical Invoice.

To obtain pre-approval for use of the Benefit Card to pay for a Covered Service Expense that exceeds the Swipe Limit, contact Us by telephone at 1-877-653-6440. The Swipe Limit is stated in the Schedule of Benefits.

PRE-APPROVAL OF USE OF THE BENEFIT CARD DOES NOT GUARANTEE BENEFITS

Our pre-approval to use the Benefit Card for an amount that exceeds the Swipe Limit does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the Policy.

SECTION 11 – TERMINATION

TERMINATION OF POLICY

All insurance will cease on termination of this Policy. This Policy will terminate on the earliest of:

(1) Nonpayment of Premiums when due, subject to the GRACE PERIOD provision in this Policy;

(2) The date We receive a request from You to terminate this Policy, or any later date stated in Your request;

(3) Fraud or intentional misrepresentation of a material fact by any Covered Person in an attempt to secure benefits for coverage, which shall be deemed to be fraud, subject to 31 days written notice by Us to You;

(4) The date We decline to renew this Policy, as stated in the DISCONTINUANCE provision in this Policy;

(5) The date of Your death, if this Policy is an individual plan; or

(6) The date a Covered Person's eligibility for insurance under this Policy ceases due to any of the reasons stated in the **ONGOING ELIGIBILITY, Section 8**, in this Policy.

We will refund any Premium paid and not earned due to Policy termination.

If this Policy is a family plan, it may be continued after Your death:

(1) By Your Spouse, if a Covered Person; otherwise,

(2) By the youngest child who is a Covered Person.

This Policy will be changed to a plan appropriate, as determined by Us, to the Covered Person(s) that continue to be covered under it. Your Spouse or youngest child will replace You as the primary Covered Person. A proper adjustment will be made in the Premium required for this Policy to be continued. We will also refund any Premium paid and not earned due to Your death.

DISCONTINUANCE

90-Day Notice: If We discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where You reside, We will provide a written notice to You at least 90 days prior to the date that We discontinue coverage. You will be offered an option to purchase any other coverage in the individual market We offer in Your state at the time of discontinuance of this Policy.

This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice: If We discontinue offering and refuse to renew all individual policies in the individual market in the state where You reside, We will provide a written notice to You and the Commissioner of Insurance at least 180 days prior to the date that We stop offering and terminate all existing individual policies in the individual market in the state where You reside.

PORTABILITY OF COVERAGE

If a person ceases to be a Covered Person due to the fact the person no longer meets the definition of Dependent under the Policy, the person will be eligible for continuation of coverage (see below). If elected, We will continue the person's coverage under the Policy by issuing an individual policy. The Premium rate applicable to the new policy will be determined based on the Residence of the person continuing coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this Policy, subject to any applicable requirements of the state in which that person resides. Any Deductible amounts and maximum benefit limits will be satisfied under the new policy to the extent satisfied under this Policy at the time that the continuation of coverage is issued.

If the original coverage contains a family deductible which must be met by all Covered Persons combined, only those expenses incurred by the Covered Person continuing coverage under the new policy will be applied toward the satisfaction of the Deductible amount under the new policy.

NOTIFICATION REQUIREMENTS

It is the responsibility of You or Your former Dependents to notify Us within 31 days of Your legal divorce or Your Dependent's marriage. You must notify Us of the address at which their continuation of coverage should be issued.

CONTINUATION OF COVERAGE

We will issue the continuation of coverage:

(1) No less than 30 days prior to a Covered Person's 26th birthday; or

(2) No less than 30 days prior to a Dependent's 28th birthday if all of the following are true:

- (a) Is the natural child, stepchild or adopted child of the Covered Person.
- (b) Is a resident of Ohio or a full-time student at an accredited higher education institution.
- (c) Is not employed by an employer that offers any health benefit plan under which the Dependent is eligible for coverage.
- (d) Is not eligible for coverage under Medicaid or Medicare.

For a child currently covered by a parent's Policy, We will provide 60-day notice informing You that Your child is about to reach the terminating age under the Policy, and advise about the option to request the extension of coverage. We will include the steps to follow to obtain the cost information, as well as the steps to take to enroll for the extension of coverage. The Covered Person is responsible for notifying Us that You wish to continue the coverage for the adult child.

(3) Within 30 days after the date We receive timely notice of Your legal divorce or Dependent's marriage. Your former dependent must pay the required Premium within 31 days following notice from Us or the new Policy will be void from its beginning;

(4) Subject to the ONGOING ELIGIBILITY provision above.

REINSTATEMENT

If You fail to pay any Premium, and You do not make a payment of Your past-due Premium by the end of the GRACE PERIOD as described in this Policy, Your coverage will terminate for nonpayment of Premium.

Under certain circumstances, Your coverage may be reinstated. You may be eligible for reinstatement if You pay all past-due Premiums within 60 days of termination. Unless termination resulted from inadvertent clerical error, You may be required to re-apply to be reinstated and receive Coverage under this Policy. Reinstatement is at Our discretion. Coverage is reinstated if We accept the Premium payment, issue a conditional receipt for the received Premium, and issue an approval of the application. If We do not issue a written disapproval within 45 days following the date of the conditional receipt of Premium, reinstatement is considered approved, unless We previously notified You in writing of Our disapproval.

If We reinstate the Policy, We will only provide coverage for accidental injury sustained after the date of reinstatement, or sickness beginning more than ten (10) days after the date of reinstatement. In other words, if You get injured or sick between losing coverage and reinstating coverage, that injury or illness will not be covered by Your Policy. Other than that provision, both You and Sidecar Health have the same rights We had under the policy immediately before the due date of the unpaid Premium, subject to any provisions endorsed or attached to the reinstated Policy.

Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

BENEFITS AFTER COVERAGE TERMINATES

Benefits for Covered Services incurred after a Covered Person ceases to be covered are provided for certain illnesses and Injuries. However, no benefits are provided if this Policy is terminated because of:

(1) A request by You;
(2) Fraud or material misrepresentation on Your part; or
(3) Your failure to pay Premiums.

The illness or injury must cause a Period of Extended Loss. The Period of Extended Loss must begin before coverage of the Covered Person ceases under this Policy. No benefits are provided for Covered Services incurred after the Period of Extended Loss ends.

In addition to the above, if this Policy is terminated because We refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state in which You live, termination of this Policy will not prejudice a claim for a Continuous Loss that begins before coverage of the Covered Person ceases under this Policy. In this event, benefits will be extended for that illness or injury causing the Continuous Loss, but not beyond the earlier of:

(1) The date the Continuous Loss ends; or
(2) 12 months after the date renewal is declined.

During coverage for a Period of Extended Loss or a Continuous Loss, as described above, the terms and conditions of this Policy, including those stated in the PREMIUMS section of this Policy, will apply as though coverage had remained in force for that illness or injury.

SECTION 12 – REIMBURSEMENT

If a Covered Person's illness or injury is caused by the acts or omissions of a Third Party, We will not cover a Loss to the extent it is paid as part of a settlement or judgment by any Third Party. However, if payment by or for the Third Party has not been made by the time We receive acceptable Proof of Loss, We will pay Benefit Amount(s) for the Covered Service(s). We will have the right to be reimbursed to the extent of benefits We provided or paid for the illness or injury if the Covered Person subsequently receives any payment from any Third Party. The Covered Person (or the guardian, legal representatives, estate, or heirs of the Covered Person) shall promptly reimburse Us from the settlement, judgment, or any payment received from any Third Party. As a condition for Our payment, the Covered Person or anyone acting on his or her behalf (including, but not limited to, the guardian, legal representatives, estate, or heirs) agrees:

(1) To fully cooperate with Us to obtain information about the Loss and its cause.

(2) To immediately inform Us in writing of any claim made or lawsuit filed on behalf of a Covered Person in connection with the Loss.

(3) To include the amount of benefits paid by Us on behalf of a Covered Person in any claim made against any Third Party.

(4) That We:

  (a) Will have a lien on all money received by a Covered Person in connection with the Loss equal to the Benefit Amount We have provided or paid.

  (b) May give notice of that lien to any Third Party or Third Party's agent or representative.

  (c) Will have the right to intervene in any suit or legal action to protect Our rights.

  (d) Are subrogated to all of the rights of the Covered Person against any Third Party to the extent of the benefits paid on the Covered Person's behalf.

  (e) May assert that subrogation right independently of the Covered Person.

(5) To take no action that prejudices Our reimbursement and subrogation rights.

(6) To sign, date, and deliver to Us any documents We request that protect Our reimbursement and subrogation rights.

(7) To not settle any claim or lawsuit against a Third Party without providing Us with written notice of the intent to do so.

(8) To reimburse Us from any money received from any Third Party, to the extent of benefits We paid for the illness or injury, whether obtained by settlement, judgment, or otherwise, and whether the Third Party's payment is expressly designated as a payment for medical expenses.

(9) That We may reduce other benefits under the Policy by the amounts a Covered Person has agreed to reimburse Us.

Furthermore, as a condition of Our payment, We may require the Covered Person or the Covered Person's guardian, if the Covered Person is a minor or legally incompetent, to execute a written reimbursement agreement. However, the terms of this provision of this Policy remain in effect regardless of whether an agreement is executed.

Notwithstanding anything to the contrary in this REIMBURSEMENT section, if the Covered Person recovers less than the full value of the claim or lawsuit with any Third Party, then Our claim to be reimbursed for benefits paid to the Covered Person shall be diminished in the same proportion as the Covered Person's interest is diminished.

We will not pay attorney fees or costs associated with the Covered Person's claim or lawsuit unless We previously agreed in writing to do so.

If a dispute arises as to the amount a Covered Person must reimburse Us, the Covered Person or the guardian, legal representatives, estate, or heirs of the Covered Person agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by Us until the dispute is resolved.

SECTION 13 – COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan. "Plan," for purposes of this Coordination of Benefits Section, is defined below. The order of benefit determination rules governs the order 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 according to 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 payments from all Plans do not exceed 100 percent of the total Allowable Expense (as defined below).

DEFINITIONS

For the purpose of this Coordination of Benefits section only, the following definitions shall apply:

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

(1) Plan includes: Group and nongroup insurance policies; Health insuring corporation (HIC) policies; Coverage under group or nongroup closed panel plans (whether insured or uninsured); Medical care components of long term care policies, such as skilled nursing care; medical benefits under group or individual automobile policies; 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; 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 policy for coverage under 1 and 2 above 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 Policy 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 Policy providing health care benefits is separate from this Plan. A policy 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 You have 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 You. 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 You is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a policy agreement is prohibited from charging You is not an Allowable Expense. The following are examples of expenses that are not Allowable Expenses:

(1) 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.

(2) If You are covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(3) If You are covered by two 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.

(4) If You are 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 policy permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because You have 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 You 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 Covered Person.

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.

ORDER OF BENEFIT DETERMINATION RULES

When You are covered by two or more Plans, the rules for determining the order of benefit payments are as follows.

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any Other Plan. 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, except 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 is excess to any other parts of the Plan provided by the policy holder.

Examples include major medical coverage that is superimposed over base hospital and surgical benefits, and insurance type coverage that is written in connection with a Closed Panel Plan to provide out-of-network benefits. 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. Each Plan determines its order of benefits using the first of the following rules that apply:

A. Non-Dependent or Dependent. The plan that covers You other than as a Dependent, (for example as an employee, Covered Person, policyholder, subscriber, or retiree) is the Primary Plan and the Plan that covers You as a Dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the Plan covering You as a Dependent, and primary to the Plan covering You as other than a Dependent, then the order of benefits between the two plans is reversed so that the plan covering You as an employee, Covered Person, policyholder, subscriber or retiree is the Secondary Plan and the Other plan is the Primary Plan.

B. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a child is covered by more than one Plan the order of benefits is determined as follows:

(1) For a child whose parents are married or are living together, whether they have ever been married:
   (a) The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan; or
   (b) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
   (c) 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.

(2) For a child whose parents are divorced or separated or not living together, whether they have ever been married:
   (a) If a court decree states that one of the parents is responsible for the 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 claim determination periods commencing after the Plan is given notice of the court decree;
   (b) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of paragraph a. above shall determine the order of benefits;
   (c) 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 child, the provisions of paragraph a. above determine the order of benefits; or
   (d) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      i. The Plan covering the Custodial Parent, first;
      ii. The Plan covering the spouse of the Custodial Parent, second;
      iii. The Plan covering the noncustodial parent, third; and then
      iv. The Plan covering the spouse of the noncustodial parent, last.

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

C. Active Employee or Retired or Laid-off Employee

The Plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a Dependent of an active employee and You are 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 under the Non-Dependent or Dependent provision above can determine the order of benefits.

D. COBRA or State Continuation Coverage

If Your coverage is provided under COBRA or under a right of continuation provided by state or other Federal law is covered under another Plan, the Plan covering You as an employee, Covered Person, subscriber, or retiree or covering You as a dependent of an employee, Covered Person, 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 under the Non-Dependent or Dependent provision above can determine the order of benefits.

E. Longer or Shorter Length of Coverage

The Plan that covered You as an employee, Covered Person, policyholder, subscriber, or retiree longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan. If the preceding rules do not determine the order of benefits, the Allowable Expenses must 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.

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 must 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 must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage. If You are 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 Plan.

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. We may get the facts We need 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 You. We need not tell, or get the consent of, any person to do this. You, to claim benefits under this Plan, must give Us any facts We need to apply those rules and determine benefits payable.

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.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than it should have paid under this Coordination of Benefit 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 You. The "amount of the payments made " includes the reasonable cash value of any benefits provided in the form of services.

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 1-877-653-6440 or via Our website at www.sidecarhealth.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 14 – NO SURPRISES ACT – EMERGENCY & AMBULANCE SERVICES

The federal No Surprises Act establishes patient protections including protections from "out-of-network" Providers' surprise bills for emergency care and other specified items or services. We will comply with these federal requirements including how We process claims from certain Emergency Care and Ambulance Services Providers.

WHAT IS "SURPRISE BALANCE BILLING"?

When You see a doctor or other health care Provider, You may owe certain out-of-pocket costs, called Cost-Sharing. Under Your Sidecar Health Plan, the only Cost-Sharing is Your Deductible. You may have other costs if You see a Provider or visit a health care facility that charges above Your plan's Benefit Amount, which is the amount Your plan pays for a particular service.

The No Surprises Act protects You from unexpected bills from Providers considered "out-of-network: or "non-participating." Traditional health plans contract with Providers to create "networks," and cover the costs of services You receive from in-network Providers. If You receive care from an out-of-network Provider, You may be billed the amount the Provider charges over what the traditional plan is willing to pay them. "Out- of-network," or "non-participating," means Providers and facilities that haven't signed a contract with a health plan.

"Out-of-network" Providers may be permitted to bill You for the difference between what Your Plan pays and the full amount charged for a service. As described in the **DEFINITIONS, Section 4**, this is called Balance Billing. "Surprise Balance Billing" is an unexpected Balance Bill. This can happen when You cannot shop for the Providers involved in Your care—like when You have an Emergency.

In the event You receive Emergency Care Covered Services, Sidecar Health will work with Providers, including the Hospital or free-standing Emergency Facility, to handle "Surprise Balance Billing" over the Benefit Amount. You are protected by the No Surprises Act from having to cover the cost of those additional charges.

If You have an Emergency Medical Condition and get Emergency Care Covered Services under Your Sidecar Health Policy, the most the Provider may bill You is Your Deductible. You **cannot** be Balance Billed for these services. This includes charges for services You may incur after You're Medically Stable, unless You give written consent and give up Your protections not to be Balance Billed for these Post-Stabilization services.

You are never required to give up Your protections from Surprise Balance Billing. As a reminder, through Your Sidecar Health Plan, You may choose any Provider or facility to receive care, and may view the Benefit Amount for Your care at www.sidecarhealth.com or by calling Member Care at 1-855-262-8461. You are not required to get care from a Provider who charges more than the Benefit Amount. Typically, if You choose to see a Provider who charges more than the Benefit Amount, the additional cost is billed to You as a Balance Bill.

In Emergency Situations, when Surprise Balance Billing isn't allowed, as described above, You also have the following protections:

(1) You are only responsible for paying Your share of the cost (i.e., Your Deductible).

(2) Your health plan will pay Emergency Care Services Providers directly.

(3) Your health plan generally must:

  (a) Cover emergency services without requiring You to get approval for services in advance (prior authorization).

  (b) Cover emergency services by "out-of-network" Providers.

(c) Base what You owe the Provider (Cost-Sharing) on what it would pay an "in-network" Provider and show that amount in Your explanation of benefits. In the case of Sidecar Health, this is the Benefit Amount.

(d) Count any amount You pay for Emergency Services or out-of-network services toward Your Deductible and Out-of-Pocket Maximum.

If You believe You've been wrongly billed, You may contact the Department of Health and Human Services No Surprises Helpdesk at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises for more information about Your rights under Federal law.

SECTION 15 - CLAIMS

OVERVIEW

We will issue a Benefit Card to You and each Covered Person on Your Policy. The Benefit Card pays cash to Providers at the time of service. As outlined below, You are responsible for submitting a Notice of Claim and Proof of Loss to Us so We can adjudicate, or process, Your claim.

If You use the Benefit Card prior to satisfying the Deductible, You will be responsible for the cost of the care. There is no Deductible for Preventive Care.

The Benefit Card will withdraw funds from Your linked Personal Account to pay the Swipe Amount until the Deductible is satisfied. If Your Personal Account does not contain funds sufficient to pay the Swipe Amount, the charge will be denied. You may identify a different Personal Account to link to the Benefit Card from the Portal while paying at the point-of-service. You may also pay the charge using a different method.

Regardless of the charge, until You have met Your Deductible, 100% of the Benefit Amount You pay for the Covered Service will be applied to Your Deductible. Charges We cover for Preventive Care will not be applied to Your Deductible. Expenses in excess of the Benefit Amount also are not applied to Your Deductible. For example, if the Provider's charge is $100, and the Benefit Amount is $90, $90 will be applied to Your Deductible, even though You will be responsible for the entire $100 charge.

Once Your Deductible is met, We will pay 100% of the Swipe Amount, up to the applicable Swipe Limit. We will treat every charge to the Benefit Card as an Estimated Benefit for the service. After We receive the Medical Invoice and process Your claim, We finalize the Benefit Amount for Covered Services You received, and take one of the following actions:

(1) Invoice You for the balance if the Swipe Amount is greater than the processed Benefit Amount;
(2) Deposit the difference into Your Sidecar Health Account if the Swipe Amount is less than the Benefit Amount;
(3) Request additional information if the Medical Invoice is not clear or it appears there is a Coordination of Benefit requirement; or
(4) Provide notice to You the claim was denied or modified, the reasons for the denial, and instructions on how to appeal the Adverse Benefit Determination (See **APPEALS, Section 16**, below).

If the Provider's charge will be greater than the Swipe Limit, be sure to submit a Pre-Bill to authorize the Swipe. By submitting the Pre-Bill, You also ensure We will review Your Medical Invoice to determine whether You experienced Unplanned Events.

You do not have to use the Benefit Card to pay for Covered Service(s). You may pay the Provider's charge with another form of payment and submit the Medical Invoice to Us as both Notice of Claim and Proof of Loss, and We will process the claim. Subject to any Deductible, We will deposit the Benefit Amount into Your Sidecar Health Account.

Funds in Your Sidecar Health Account may be used to cover Your medical expenses, pay for future Premiums, or be received as a direct payment to You in the form of a check.

You can view the Benefit Amounts and utilize the cost estimator tool available through the Portal to exercise control over Your healthcare spending.

NOTICE OF CLAIM

We must receive Notice of Claim within 90 days of the date of service, or the date the Loss began, or as soon

as reasonably possible. You may elect to give Notice of Claim in a different manner from one claim to the next. Notice is given by or on behalf of You or a Covered Person to Us by (1) using the Benefit Card; (2) submitting a claim or Proof of Loss/Medical Invoice in the Portal; or (3) mailing a written claim or Proof of Loss/Medical Invoice to Us, as set forth below.

(1) If using the Benefit Card, Notice of Claim is deemed given when an electronic transaction for a Covered Service is initiated by using the Benefit Card; or

(2) You may provide Notice of Claim through the Portal by uploading a picture of the Medical Invoice; or

(3) You may provide Notice of Claim by mailing Us a copy of the Medical Invoice.

If a Notice of Claim is not accompanied by a Medical Invoice, You must still submit a Medical Invoice to Us within 90 days of the date of Loss. Use of the Benefit Card provides Us notice a claim for benefits will be made by a Covered Person, but this is not the same as You submitting an actual claim/Proof of Loss/Medical Invoice. You must provide Proof of Loss to Us within 90 days of the date of the Loss.

CLAIM FORMS

Claims under this Policy are made by submitting a Medical Invoice to Us either electronically through the Portal or by mailing the Medical Invoice to Us. If the claim submission information is not provided to You before the 16th day after the date on which You gave Your Notice of Claim, You will be considered to have complied with the requirements of this Policy as to the claim form if and when You submit a copy of the Medical Invoice within the time fixed in this Policy for filing Proofs of Loss.

This Plan does not rely on the use of a standard claim form as described in applicable state law. However, if a You or Your Provider submit a claim on a standard claim form, We will comply with the timeline for processing the claim in accordance with the law.

PROOF OF LOSS – MEDICAL INVOICE

You or Your covered Dependent must give Us written Proof of Loss within 90 days of the Loss or as soon as is reasonably possible. Proof of Loss furnished more than one year late will not be accepted unless You or Your covered Dependent had no legal capacity in that year.

Proof of Loss may be delivered to Us by either (1) uploading a picture of the Medical Invoice through the Portal or (2) mailing Your Medical Invoice to Us.

COOPERATION PROVISION

Each Covered Person, or other person acting on his or her behalf, must cooperate fully with Us to assist Us in determining Our rights and obligations under the Policy. Each Covered Person, as part of participating in the receipt of services:

(1) Authorizes any insurer, employer, organization, and Provider to release to Us any and all information relating to the administration of and coverage under this Plan including but not limited to past, present, and future medical records, health care examinations, treatments, and diagnoses; and

(2) Authorizes Us to release the information described above to administer this Policy.

You agree to assist Us in obtaining this information if needed. As part of this Policy, You agree to execute a release and authorization for Us to obtain medical records. Failure to assist Us in obtaining the necessary information when requested may result in the delay or rejection of Your claim(s). We reserve the right to reject or suspend a claim based on lack of medical information or records.

TIME FOR PAYMENT OF CLAIMS

Typically, We will pay benefits or give an Adverse Benefit Determination within 30 days after Our receipt of a "clean" written or electronic claim in the form of a written Proof of Loss. A clean claim is a claim that contains substantially all the required data elements necessary for accurate processing, without obtaining additional information from the Provider of the service or from a third party. Even if We receive all the information We need to treat a submission as a claim or Proof of Loss, We might need additional information to determine whether the claim is payable. If We need additional information, We will ask You to furnish it to Us, and We will suspend further processing of Your claim until the information is received. You have 90 days to provide the additional information to Us. We may request the information directly from Your Provider if necessary. However, You remain responsible for making sure We get the information on time.

If it is necessary for Us to ask for additional information, We will pay benefits or give an Adverse Benefit Determination within 21 days after We receive the additional information. If We do not receive the requested additional information, Your claim will be considered denied at the expiration of the 90-day period.

If We fail to deny or pay a clean written or electronic claim within the time periods, the amount of the overdue claim will include an interest payment computed based on the number of days that have elapsed between the date payment is due and the date payment is made. The interest rate for determining the amount of interest due will equal an annual percentage rate of 18%. Our failure to comply with the time limits in this section shall not have the effect of requiring coverage for an otherwise non-covered claim. Proof of Loss may be delivered to Us by either (1) uploading a picture of the Medical Invoice through the Portal or (2) mailing Your Medical Invoice to Us.

PAYMENT OF CLAIMS

Except as set forth in this provision, all benefits are payable to You. Any accrued benefits unpaid at Your death, or Your Dependent's death may, at Our option, be paid either to the beneficiary or to the estate. If any benefit is payable to Your or Your Dependent's estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, We may pay up to $1,000 to any relative who, in Our opinion, is entitled to it.

If, at any time, the Swipe Amount paid by Us exceeds the Benefit Amount for the applicable Covered Service, then We will invoice You the balance. You may reimburse Us such difference either by submitting an electronic payment through the Portal or by mailing a check to Us. If You fail to reimburse Us within 30 days of the date on which We notify You of the reimbursement amount through the Portal, We may suspend Your use of the Benefit Card. We may suspend Your use of the Benefit Card if You have more than $2,000 of outstanding amounts owed to Us. Suspension of the Benefit Card does not limit Your ability to obtain benefits for eligible Covered Services.

In addition, fraud or an intentional misrepresentation of a material fact by You or any Covered Person in an attempt to secure benefits or coverage when using the Benefit Card shall be fraud in the inducement of Your contractual relationship with Us and shall result in termination of coverage for You subject to 31 days written notice by Us. For termination of coverage with a retroactive effect, 31 days advance written notice will be provided to You. This decision may be appealed through the Grievance process.

UNPAID PREMIUM

At the time of payment of a claim under this Policy, any Premium then due and unpaid may be deducted from the claim payment.

RECOVERY OF OVERPAYMENT

If benefits are overpaid or paid in error, We have the right to recover the amount overpaid or paid in error by any of the following methods.

(1) A request for lump sum payment of the amount overpaid or paid in error; or

(2) Reduction of any proceeds payable under this Policy by the amount overpaid or paid in error.

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

FOREIGN CLAIMS INCURRED FOR EMERGENCY CARE

Claims incurred outside of the United States for Emergency Care and treatment of a Covered Person must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper Proof of Loss.

ASSIGNMENT

We will pay Benefit Amounts directly to a Provider who provides Covered Services to You if:

(1) You use Your Benefit Card at a Provider to pay for Covered Services;

(2) You request an assignment of Your benefits under this Policy, in writing through the Portal or by contacting Us at the toll-free number, 1-877-653- 6440, and We approve such assignment; or

(3) We are obligated to pay such Provider to comply with Our obligations under any law, regulation, or contract.

Any assignment to a Provider providing the Covered Service, with or without Our approval, shall not confer upon the Provider, any right or privilege granted to You under the Policy except for the right to receive benefits, if any, We have determined to be due and payable. We are not responsible for the validity of assignments requested by You. The assignee only takes such rights as the assignor (You) possessed and such rights are subject to state and federal laws and the terms of this Policy.

In accordance with applicable Ohio law, for Covered Services rendered at a Hospital, We will accept and honor a completed and validly executed assignment of benefits with a Hospital by You, unless We have notified the Hospital in writing within the past year of the conditions under which We will not accept and honor an assignment of benefits. In no event will We refuse to accept and honor a validly executed assignment of benefits with a Hospital for Medically Necessary Hospital services provided to a Covered Person on an emergency basis.

CUSTODIAL PARENT

This provision applies if the parents of a covered Eligible Child are divorced or legally separated and both the custodial parent and the non-custodial parent are subject to the same court or administrative order establishing custody. The custodial parent, who is not a Covered Person, will have the rights stated below if We receive a copy of the order establishing custody. Upon request by the custodial parent, We will:

(1) Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the Policy;

(2) Accept claim forms and requests for claim payment from the custodial parent; and

(3) Make claim payments directly to the custodial parent for claims submitted by the custodial parent.

Payment of claims to the custodial parent, which are made under this provision, will fully discharge Our obligations. A custodial parent may, with Our approval, assign claim payments to the Hospital or Medical Practitioner providing treatment to an Eligible Child.

PHYSICAL EXAMINATION

We shall have the right and opportunity to examine a Covered Person while a claim is pending or while a dispute over the claim is pending. These examinations are made at Our expense and as often as We may reasonably require.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty days after written Proof of Loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written Proof of Loss is required to be furnished. No action at law or in equity may be brought against Us under the Policy for any reason unless the Covered Person first completes all the steps in the complaint/appeal procedures made available to resolve disputes in Your state under the Policy. After completing that complaint/appeal procedures process, if You want to bring legal action against Us on that dispute, You must do so within three years of the date We notified You of the final decision on Your complaint/appeal.

GRIEVANCE PROCESS

You or Your designee may submit a Grievance in writing. Depending on the nature of the Grievance and whether a response is requested, We will respond verbally and/or in writing within thirty (30) business days following receipt of the Grievance, or should a Covered Person's medical condition necessitate an expedited review, a response within seven (7) days.

The response will state the reason for Our decision, inform the Covered Person of the right to pursue a further review, and explain the procedures for initiating such review. Grievances will be considered when measuring the quality and effectiveness of Our products and services.

HOW TO CONTACT US

Mailing Address:

Sidecar Health Insurance Company
Attn: Grievance/Appeal Request
340 S. Lemon Ave.
Suite 7028
Walnut, CA 91789

Phone No: 1-877-653-6440
TTD No: 711
Fax No. 866-376-2053
Website: www.sidecarhealth.com
Email: grievances@sidecarhealth.com

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 Plan. Examples of the use of 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 description in this Plan. 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 the enrollment, use of the Benefit Card, 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 Plan.

SECTION 16 – APPEALS, GRIEVANCES AND EXTERNAL REVIEW

OVERVIEW

Claims and Internal Appeals Procedures. When a health insurance plan denies a claim for a treatment or service You have already received, You, or someone You have authorized to speak on Your behalf (an authorized representative), may request an appeal of the Plan's decision. If the Plan rescinds Your coverage or denies Your application for coverage, You may also appeal the Plan's decision. When the Plan receives Your first appeal, We are required to review Our own decision, called an "internal appeal." Whenever the Plan makes a claim decision, it is required to notify You, which is called providing Notice of an Adverse Benefit Determination. This Notice must include:

(1) The reasons for the Plan's decision;

(2) Your right to file appeal of the claim decision

(3) Your right to request an external review of the decision; and

(4) The availability of a Consumer Assistance Program at The Ohio Department of Insurance.

(5) If You do not speak English, You may be entitled to receive appeals information in Your native language upon request.

(6) When You request an internal appeal, We must give You Our decision as soon as possible, but no later than:
   (a) 72 hours after receiving Your request when You are appealing the denial of a claim for Urgent care. (If Your appeal concerns Urgent Care, You may be able to have the internal appeal and external reviews take place at the same time.)
   (b) 30 days for appeals of denials of services You have not already received
   (c) 60 days for appeals of denials of services You have already received.

(7) No extensions of the maximum time limits are permitted unless You consent.

Continuing Coverage. The Plan cannot terminate Your benefits until all Your appeals have been exhausted. **However, if the Plan's decision is ultimately upheld, You may be responsible for paying any outstanding claims or reimbursing the Plan for claims payments it made during the time of the appeals.**

Cost and Minimums for Appeals. There is no cost to You to file an appeal and there is no minimum amount required to be in dispute.

Emergency medical services. If the Plan denies a claim for an Emergency medical service, Your appeal will be handled as an urgent appeal. The Plan will advise You at the time We deny the claim that You can file an expedited internal appeal. If You file for an *expedited internal appeal*, You may also file for an *expedited external review* (see the SIMULTANEOUS URGENT CLAIM, EXPEDITED INTERNAL REVIEW AND EXTERNAL REVIEW section).

Your rights to file an appeal of denial of health benefits. You or Your authorized representative, such as Your health care Provider, may file the appeal for You, in writing, either by mail or by facsimile (fax). For an urgent request, You may also file an appeal by telephone.

Please include in Your written appeal or be prepared to tell Us the following:

(1) Name, address and telephone number of the insured person;

(2) The insured's health plan identification number;

(3) Name of health care provider, address and telephone number;

(4) Date the health care benefit was provided;

(5) Name, address and telephone number of an authorized representative (if appeal is filed by a person other than the insured); and

(6) A copy of the notice of Adverse Benefit Determination.

Rescission of coverage. If the Plan rescinds Your coverage, You may file an appeal according to the following procedures. The Plan cannot terminate Your benefits until all the appeals are exhausted. Since a rescission means no coverage ever existed, if the Plan's decision to rescind is upheld, You will be responsible for payment of all claims for Your health care services.

Time Limits for filing an internal appeal. You must file the internal appeal within 180 days of the receipt of the Notice of Adverse Benefit Determination. Failure to file within this time limit may result in the Plan declining to consider the appeal.

In general, the Plan may extend the time for providing a decision regarding an internal appeal for 15 days after the expiration of the initial 60-day period described above, if the Plan determines an extension is necessary for reasons beyond the Our control. There is no provision for extensions in the case of appeals involving claims for Urgent Care and Emergency Care.

Time Limits for an External Appeal. You have 180 days to file for an external review after receipt of Our final Adverse Benefit Determination (after all internal appeals are exhausted).

Your Rights to a Full and fair review. The Plan must allow You to review the claim file and to present evidence and testimony as part of the internal appeals process.

(1) The Plan must provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to give You a reasonable opportunity to respond prior to that date; and

(2) Before the Plan can issue a final internal Adverse Benefit Determination based on a new or additional rationale, You must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

(3) The Adverse Benefit Determination must be written in a manner understood by You, or if applicable, Your authorized representative and must include all of the following:

(a) The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);

(b) Information sufficient to identify the claim involved, including the date of service, the health care provider;

(c) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

(4) As a general matter, the Plan may deny claims at any point in the administrative process on the basis it does not have sufficient information; such a decision; however, will allow You to advance to the next stage of the appeals process.

Other Resources to help You

Department of Insurance: For questions about Your rights or for assistance You may also contact the Consumer Services Division at The Ohio Department of Insurance (800) 686-1526.

Language services are available from the health benefit plan and from The Ohio Department of Insurance.

Your rights to appeal and the instructions for filing an appeal are described in the provisions following this Overview.

INTERNAL CLAIMS AND APPEALS

Simultaneous Urgent Claim, Expedited Internal Appeal and External Review:

You, or Your authorized representative, may request an expedited ***external review*** if both the following apply:

(1) You filed a request for an expedited ***internal review***; and

(2) After an initial or final Adverse Benefit Determination, either of the following applies:

(a) Your treating Physician certifies the Adverse Benefit Determination involves a medical condition that could seriously jeopardize Your life or Your health, or would jeopardize Your ability to regain maximum function, if treated after the time frame of a standard external review; or

(b) The final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which You received emergency services, but have not yet been discharged from a facility.

Pre-Service Appeal of a Claim Denial (Prospective)

If Your appeal is from a denial of a claim for care You have not yet received, We will notify You of Our decision as soon as possible but no later than 30 days after We receive Your appeal. If We need more information to make a determination, We will contact You, telling You the reasons why We need more information and request the additional information from You. We will also tell You the time and the date when We expect to have a decision for You if We need more time. We need Your consent to extend the time for Our review. If We do not receive the additional information requested, We will make Our determination based upon available information. This is also known as a "prospective review."

Post-Service Appeal of a Claim Denial (Retrospective)

If Your appeal is for a denial of a claim for care You already received, We will notify You of Our decision as soon as possible but no later than 60 days after We have received Your appeal. If We need more time, We will contact You, telling You about the reasons why We need more time and the date when We expect to have a decision for You, which should be no later than 15 days, provided We determine such an extension is necessary due to matters beyond Our control, and We notify You prior to the expiration of the initial 60-day period. If the reason We need more time to make a decision is because You have not given Us necessary information, You will have 45 days from the date We notify You to give Us the information. We will describe the information needed to make Our decision in the notice We send You. This is also known as a "retrospective review."

The Plan will notify You of its appeals determination as soon as possible but no later than 5 days after the Adverse Benefit Determination is made.

The Plan will let You know before the end of the first 60-day period, explaining the reason for the delay, requesting any additional information needed, and advising You when a final decision is expected. If more information is requested, You have at least 45 days to supply it. The claim then must be decided no later than 15 days after You supply the additional information or the period given by the Plan to do so ends, whichever

comes first. The Plan must get Your consent if it wants more time after its first extension. The Plan must give You notice that Your claim has been denied in whole or in part (paying less than 100% of the Benefit Amount) before the end of the time allotted for the decision.

EXTERNAL REVIEW

Right to External Review

Under certain circumstances, You have a right to request an external review of Our Adverse Benefit Determination by an independent review organization (IRO). If You filed internal claims and appeals according with the procedures of this Plan, and the Plan denied or refused to change its decision; if the Plan failed, because of its actions or its failure to act, to provide You with a final determination of Your appeal within the time permitted; or if the Plan waives, in writing, the requirement to exhaust the internal claims and appeals procedures; You may make a request for an external review of an Adverse Benefit Determination.

All requests for an external review must be made to the Plan within 180 days of the date of the notice of the Plan's final Adverse Benefit Determination. Standard requests for an external review must be provided in writing; requests for expedited external reviews, including experimental/investigational, may be submitted orally or electronically. When an oral or electronic request for review is made, written confirmation of the request must be submitted to the Plan no later than 5 days after the initial request was made.

Non-urgent Request for an External Review

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

(1) The name and contact information for the assigned independent review organization or the Director of the Department of Insurance, as applicable, for the purpose of submitting additional information; and

(2) Except for when an expedited request is made, a statement that You may, with 10 business days after the date of receipt of the notice, submit, in writing, additional information for either the independent review organization or the Director of the Department of Insurance to consider when conducting the external review.

If Your request is not complete, the Plan will notify You in writing and include information about what is needed to make the request complete.

If the Plan denies Your request for an external review on the basis that the Adverse Benefit Determination is not eligible for an external review, the Plan will notify You, in writing, the reasons for the denial and that You have a right to appeal the decision to the Director of the Department of Insurance.

If the Plan denies Your request for an external review because You failed to exhaust the Internal Claims and Appeals Procedure, You may request a written explanation, which the Plan will provide to You within 10 days of receipt of Your request, explaining the specific reasons for its assertion that You were not eligible for an external review because You did not comply with the required procedures.

Request for external review to Director of Department of Insurance. If the Plan denies Your request for an external review, You may file a request for the Director of the Department of Insurance to review the Plan's decision by contacting Consumer Services Division at 800-686-1526 between 8:00 a.m. and 5:00 p.m., Eastern Standard Time or by sending a written request addressed to: Consumer Services, The Ohio Department of Insurance, 50 West Town St., Suite 300, Columbus, Ohio 43215. Information about external reviews is also available on the Department's website: www.insurance.ohio.gov.

If Director upholds the Plan's decision. If You file a request for an external review with the Director, and if the Director upholds the Plan's decision to deny the external review because You did not follow the Plan's internal claims and appeals procedures, You must resubmit Your appeal according to the Plan's internal claims and appeals procedures within 10 days of the date of Your receipt of the Director's decision. The clock will begin running on all the required time periods described in the internal claims and appeals procedures when You receive this notice from the Director.

If the Plan's failure to comply with its obligations under the internal claims and appeals procedures was considered (1) de minimis; (2) not likely to cause prejudice or harm to You (claimant); (3) because We had a good reason or Our failure was caused by matters beyond Our control; (4) in the context of an ongoing good faith exchange of information between the Plan and You (claimant) or Your authorized representative; and (5) not part of a pattern or practice of Our not following the internal claims and appeals procedures, You will not be deemed to have exhausted the internal claims and appeals requirements. You may request an explanation of the basis for the Plan's asserting that its actions meet this standard.

Expedited external review. You may have an expedited external review if Your treating physician certifies the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the Your life or health (claimant), or would jeopardize Your ability to regain maximum function if treated after the time frame for a standard external review; or the final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which You received emergency services, but have not yet been discharged from a facility. The request may be made orally or electronically by You or Your health care Provider.

Expedited external review for experimental and/or investigational treatment. You may request an external review of an Adverse Benefit Determination based on the conclusion that a requested health care service is experimental or investigational, except when the requested health care service is explicitly listed as an excluded benefit under the terms of the health benefit plan. To be eligible for an external review under this provision, Your treating Physician shall certify that one of the following situations is applicable:

(1) Standard health care services have not been effective in improving Your condition;

(2) Standard health care services are not medically appropriate for You; or

(3) There is no available standard health care service covered by the health plan issuer that is more beneficial than requested health care service.

The request for an expedited external review under this provision may be requested orally or electronically. For Expedited/Urgent requests, Your health care Provider can orally make the request on Your behalf.

If the request for an expedited external review is complete and eligible, the Plan will immediately provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination in question to the assigned independent review organization (IRO) by telephone, facsimile or other available expeditious method. If the request is not complete, We will notify You immediately, including what is needed to make the request complete.

Independent Review Organization. An external review is conducted by an independent review organization selected on a random basis as determined in accordance with Ohio law. The IRO will provide You with a written notice of its decision to either uphold or reverse the Plan's Adverse Benefit Determination within 30 days of receipt of a standard external review (not urgent). If an expedited external review (urgent) was requested, the IRO will provide a determination as soon as possible or within 72 hours of receipt of the expedited request. The IRO's decision is binding on the Plan. If the IRO reverses the health benefit plan's decision, the Plan will immediately provide coverage for the health care service or services in question.

If the Director or IRO requires additional information from You or Your health care Provider, the Plan will tell You what is needed to make the request complete.

If the Plan reverses its decision. If the Plan decides to reverse its Adverse Benefit Determination before or during the external review, the Plan will notify You, the IRO, and the Director within one business day of the decision.

After receipt of health care services. No expedited review is available for Adverse Benefit Determinations made after receipt of the health care service or services in question.

Emergency medical services. If the Plan denies coverage for an Emergency medical service based on Medical Necessity, We will also advise at the time of denial that You may request an expedited internal and external review of the Plan's decision.

Review by the Director of Insurance. If the Plan made an Adverse Benefit Determination based on a Policy issue (e.g., whether a service or services are covered under Your policy of insurance), You may request an external review by the Director of the Department of Insurance.

If the IRO and Director uphold the Plan's decision, You may have a right to file a lawsuit in any court having jurisdiction.

SECTION 17 – GENERAL PROVISIONS

ENTIRE POLICY

This Policy, with the application, Schedule of Benefits and any rider-amendments is the entire policy between You and Sidecar Health. No change in this Policy will be valid unless it is approved by one of Our officers and noted on or attached to this Policy. No agent may:

(1) Change this Policy;
(2) Waive any of the provisions of this Policy;
(3) Extend the time for payment of Premiums; or
(4) Waive any of Our rights or requirements.

NON-WAIVER

If We or You fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations, or exclusions of the Policy, that will not be considered a waiver of any rights under the Policy. A past failure to strictly enforce the Policy will not be a waiver of any rights in the future, even in the same situation or set of facts.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the Covered Person on the application of this Policy that relates to insurability will be used to void/rescind the insurance coverage or deny a claim unless:

(1) The misrepresented fact is contained in a written application, including amendments, signed by a Covered Person;
(2) A copy of the application, and any amendments, has been furnished to the Covered Person(s), or to their beneficiary; and
(3) The misrepresentation of fact was intentionally made and material to Our determination to issue coverage to any Covered Person.

A Covered Person's coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. “Rescind” has a retroactive effect and means the coverage was never in effect. If We void/rescind Your Policy, You may appeal Our determination.

RESCISSIONS

No misrepresentation of fact made regarding a Covered Person during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

(1) The misrepresented fact is contained in a written application, including amendments, signed by a Covered Person;
(2) A copy of the application, and any amendments, has been furnished to the Covered Person(s), or to their beneficiary; and
(3) The misrepresentation of fact was fraudulent or intentionally made and material to Our determination to issue coverage to any Covered Person.

A Covered Person's coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. “Rescind” has a retroactive effect and means the coverage was never in effect. We will provide You with 30 days advanced written notice in the event of a Rescission. If We void/rescind Your Policy, You may appeal Our determination.

REPAYMENT FOR FRAUD, MISREPRESENTATION OR FALSE INFORMATION

During the first two years a Covered Person is covered under the Policy, if a Covered Person commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any Covered Person under this Policy or in filing a claim for Policy benefits, We have the right to demand that Covered Person pay back to Us all benefits that We provided or paid during the time the Covered Person was covered under the Policy.

NON-INSURANCE REWARDS AND INCENTIVES

We may offer incentives to You if You participate in programs that help reduce Our administrative expenses. Programs that make retaining coverage more convenient. Programs that educate You. Programs that provide input on Sidecar Health and its products. Such programs may include learning more about health insurance and/or specific Sidecar Health Plan features. Programs may include participating in surveys about Sidecar Health and its products and services. Programs may include providing other feedback to Us for the improvement of Our products and services. Programs may include earning rewards for healthy behaviors. We may also offer giveaways and discounts to You, such as discounts on select vendor partner products and services. The products and services available under this program are not Covered Services under the Plan. Program features are not guaranteed under the Plan 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.

CONFORMITY WITH STATE LAWS

Any part of this Policy in conflict with the laws of the state in which this Policy was issued on this Policy's Effective Date or on any Premium due date is changed to conform to the minimum requirements of that state's laws.

CONFORMITY WITH FEDERAL NO SURPRISES ACT AND STATE SURPRISE BILLING LAWS

Ohio's House Bill 388, codified in ORC §3902.50 through §3902.54, as well as the federal No Surprises Act, establish patient protections including from out-of-network providers' surprise bills (“balance billing”) for emergency care and other specified items or services. We will comply with these new state and federal requirements including how We process claims from certain out-of-network providers.

SIDECAR HEALTH INSURANCE COMPANY

("Sidecar Health")
a stock company domiciled in the State of Ohio

SIDECAR HEALTH OHIO ACA SILVER OFF-EXCHANGE (SEE ANY DOCTOR + PREMIUM MEMBER SUPPORT) CHILD DENTAL/VISION SCHEDULE OF BENEFITS

PLAN INFORMATION
Sidecar Health Ohio ACA Silver Off-Exchange (See Any Doctor + Premium Member Support) **Child Dental/Vision** Primary Insured: Jeff New Year Policy Number: ACA2302266 Date of Birth: 05/18/1982 Original Effective Date: 01/01/2023 Last Coverage Change Date: 01/01/2023

MEMBER RESPONSIBILITIES

Annual Deductible per Calendar Year	
Individual: $5,250	Family: $10,500

Out-Of-Pocket Maximum per Calendar Year	
Individual: $5,250	Family: $10,500

Member's Mid-Policy Year Amendments:

(Internal Use Only)

Maximum Swipe Amount in Single Transaction on Benefit Card. Without First Submitting a Medical Invoice to Us for Pre-Approval to Use Benefit Card

Facility Type Where Covered Service is Provided	Swipe Limit
At a Physician's office, Hospital, Outpatient Surgical Facility, freestanding emergency facility, Urgent Care Center, or freestanding pharmacy-only facility	$2,000
At any other facility, including retail pharmacies that offer more than pharmacy-only services	$200

Limitations on Covered Services. Terms of coverage and exclusions can be found in your Policy at Section 5 - Covered Service Benefits and Section 6 - General Limitations and Exclusions.

COVERED SERVICE	MAXIMUM LIMITATION PER CALENDAR YEAR
Dental Services related to accidental injury	**$3,000 per injury**
Durable Medical Equipment	
Mastectomy Bras	**4 Mastectomy Bras**
Continuous Passive Motion (CPM) Machine	**1 per Covered Person following covered joint surgery**
Wigs necessitated by hair loss due to cancer treatments or traumatic burns	**1 per Covered Person**
Foot Orthotic Device	**1 pair per Covered Person**
Pediatric Vision	
Pediatric Routine Vision Screening	**1 screening**
Pediatric Frames	**1 pair of frames**
Pediatric Lenses or Contacts	**1 pair of prescription lenses or contacts**
Transplant Coverage	
Unrelated donor searches for bone marrow/stem cell	**$30,000 per covered transplant**
Travel Expenses (transportation and lodging related to covered transplant)	**$10,000 per covered transplant**

Home Care Services[#]	**100 visits**
[#]Important Explanations for Home Care Services: *The limit for Home Care Services does not include home Infusion Therapy or Private Duty Nursing rendered at home.*	

COVERED SERVICE	MAXIMUM LIMITATION PER CALENDAR YEAR
When therapy services are provided in the home (including physical therapy, occupational therapy, speech, cardiac rehabilitation, and pulmonary rehabilitation) as part of home health care services, they are not subject to the separate visit limits for Therapy Services. Rather, each therapy service provided in the home will count as one Home Care Service visit.	
Private Duty Nursing[##]	**90 visits**
[##]Private Duty Nursing is covered only when provided through the Home Care Services benefit.	
Skilled Nursing Facility	**90 days**
Inpatient Therapy Services[**]	
Physical Therapy	**20 visits**
Occupational Therapy	**20 visits**
Speech Therapy	**20 visits**
Rehabilitation Therapy Services[***]	
Rehabilitative Therapies whether rendered in a Rehabilitation Facility, Physician Home Visit, Physician Office or as Outpatient services.	
Physical Therapy	**20 visits**
Occupational Therapy	**20 visits**
Speech Therapy	**20 visits**
Chiropractic Care/Manipulation Therapy	**12 visits**
Cardiac Rehabilitation	**36 visits**
Pulmonary Rehabilitation	**20 visits**

***Important Explanations for Therapy Services:*

Therapy Services visit limitations are not applicable to clinical therapeutic intervention services for children ages 0 to 21 with a medical diagnosis of Autism Spectrum Disorder. Such services are instead limited to 20 hours per week.

****Important Explanations for Therapy Services:*

Therapy services rendered in the home as part of Home Care Services will be subject to the Home Care Services visit limit; outpatient Therapy Services visit limits will not apply.

If different types of Therapy Services are performed, then each different type of Therapy Service performed will be considered a separate therapy visit. Each therapy visit will count against the applicable maximum visits listed above. For example, if both a Physical Therapy Service and a Chiropractic Care/Manipulation

COVERED SERVICE	MAXIMUM LIMITATION PER CALENDAR YEAR
Therapy Service are performed, they will count as both one Physical Therapy visit and one Chiropractic Care/Manipulation Therapy visit. *When a Pulmonary Rehabilitation Service is rendered as part of a Physical Therapy Service, the Physical Therapy limit will apply instead of the Pulmonary Rehabilitation visit limit.*	

† The Deductible does not apply to any of the following:

- Preventive Care. Screenings received for diagnostic purposes (as billed by the provider or facility) are not considered to be Preventive Care and will be subject to the Deductible.

SIDECAR HEALTH INSURANCE COMPANY

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MAJOR MEDICAL EXPENSE INSURANCE POLICY AMENDMENT

The following items amend language originally provided in Policy form SHIC-PY2023OH-MAJMED-ON/OFF-IND. Only the items represented below are affected by this Policy Amendment.

It is understood and agreed that the definition of **Benefit Amount** is amended to insert the following sentence into the "Benefit Amount for Emergency Care and Ambulance" section as follows:

> "For purposes of calculating Cost-Sharing for fixed wing and rotary wing air Ambulance services, the Benefit Amount will be the lesser of the provider charge or the qualifying payment amount calculated using an eligible database as defined by federal Surprise Billing regulations."

This Policy Amendment takes effect and expires at the same time as the Policy to which it is attached. This Amendment is subject to all of the terms and conditions of the Policy not inconsistent herewith.

This Policy Amendment is issued in, and governed by the laws of, the State of Ohio.

Patrick G. Quigley
Chief Executive Officer
Sidecar Health Insurance Company