Passport by Molina Healthcare Marketplace

2026

Agreement and Individual Evidence of Coverage

Passport by Molina Healthcare
5100 Commerce Crossings Drive
Louisville, KY 40229

PASSPORT BY MOLINA HEALTHCARE

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READ YOUR POLICY CAREFULLY. This cover sheet provides only a brief outline of some of the important features of your policy. This cover sheet is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. IT IS THEREFORE IMPORTANT THAT YOU READ YOUR POLICY.

A Table of Contents follows, showing you where to look for information concerning specific topics.

This policy is a legal contract between you and Molina Healthcare of Kentucky, Inc., doing business as Passport by Molina Healthcare.

Entire Contract; Changes: This policy, including the indorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be indorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Pediatric Dental Notice: NOTICE: THIS AGREEMENT DOES NOT INCLUDE PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT. THIS COVERAGE IS AVAILABLE IN THE HEALTH INSURANCE MARKETPLACE. IT CAN BE PURCHASED AS A STAND-ALONE PRODUCT. PLEASE CONTACT YOUR INSURANCE CARRIER, AGENT, OR THE FEDERALLY FACILITATED HEALTH INSURANCE MARKETPLACE IF YOU WISH TO PURCHASE PEDIATRIC DENTAL COVERAGE OR A STANDALONE DENTAL PRODUCT.

Covered Services for American Indians and Alaska Natives (AI/AN):

- AI/AN Members enrolled in Zero Cost-Sharing plans won’t incur Cost-Sharing when they receive Covered Services from Participating Providers.
- AI/AN Members enrolled in Limited Cost-Sharing plans won’t incur Cost-Sharing when they receive Covered Services from an Indian Health Care Provider, or from another Provider, provided they have a referral from an Indian Health Care Provider.
- For more information, please visit PassportHealthPlan.com/Marketplace.

Notice of Multiple Plans: NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

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

Right to Examine: Newly enrolled Subscribers have the right to return this Agreement until midnight of the tenth day after the date on which the Subscriber receives the Agreement, by returning the Agreement to Passport or an agent of Passport. No reason need be stated for the return. Passport will treat this Agreement as if it had never been issued and will return all Premium Payments to the Subscriber. If the Subscriber returns this Agreement under this provision, they will be responsible for payment of any health care service they or a Dependent received before they returned the Agreement.

Thank You for Choosing Passport by Molina Healthcare!

As an organization that's been taking care of kids, adults, and families for 40 years, Passport is excited to be your Plan.

We're sending you this 2026 Passport Agreement and Individual Certificate of Coverage ("Agreement") to tell you:

- How you can get services through Passport, including:
  - Types of care and how to find it
  - Self-service for your account
  - Plan details
  - Eligibility
- The terms and conditions of coverage under this Agreement
- Benefits and coverage as a Passport Member
- Checking on Prior Authorization status
- How to contact Passport

Please read this document carefully. If you have any questions or concerns, please reach out to Customer Support at PassportHealthPlan.com/Marketplace or (833) 644-1621.

We look forward to serving you,

Passport by Molina Healthcare

WHERE TO GO FOR CARE AND HELP

Service	Need	Where to Go
Emergency Room	You should go to the ER for sudden injury or sickness such as: • A lot of bleeding • A very bad burn • Trouble breathing • Drug overdose • Chest pain • Broken bones	Go to the nearest Emergency Room or call 911 if you have an emergency.
Urgent Care	Urgent Care Centers treat medical problems that may not wait until your next doctor's visit but are not life threatening. • Twisted or sprained ankle • Cough, cold, sore throat • Cuts, bumps and sprains • Fever or flu symptoms • General wound care	Passport has a network of Urgent Care facilities. To find your nearest in-network Urgent Care visit PassportHealthPlan.com/Marketplace
Getting Care	• Primary Care • Virtual Care • After-Hour Care	• Your Primary Care Provider is your main healthcare provider in non-emergency situations. Your annual visit is always covered. To search for an in-network provider near you, visit PassportHealthPlan.com/Marketplace • See a doctor from anywhere, anytime virtually with Teladoc. Visits are unlimited and covered under your plan. Visit Teladoc.com/molinamarketplace to sign up and schedule an appointment. • Highly trained nurses are available to assist you 24 hours a day. Call the Nurse Advice Line at (833) 644-1622
Self Service for your Account	• Find or change a doctor • View benefits and Member Handbook • View or print ID card • Track claims	• Make an account on MyMolina.com to access your Member Portal. • Download the Molina Mobile App for healthcare on-the-go.

	• Make a payment or sign up for Autopay	• Go to Molinapayment.com to make a one-time payment.
Plan Details	• Answers about your plan, programs, services, or prescription drugs • ID card support • Access to care • Payment questions	**Passport Customer Support Center** **(833) 644-1621** Monday through Friday, 8am – 6pm Eastern time
Eligibility & Enrollment	• Eligibility questions • Add a Dependent • Report change of address or income	kynect health coverage https://kynect.ky.gov (855) 459-6328

Interpreter Services: Passport offers interpreter services to assist any Member who may require language support in understanding and obtaining health coverage under this Agreement. These services are provided by Passport at no additional cost to the Member. Passport offers both oral interpretation and written translation services for materials vital for a Member's understanding their health care coverage. Members who are deaf or hard of hearing can use the Telecommunications Relay Service by dialing 711.

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Policy Issuance: This Healthcare Agreement and Individual Certificate of Coverage (also called the "Agreement") is issued by Molina Healthcare of Kentucky, Inc., doing business as Passport by Molina Healthcare ("Passport"), to the Subscriber or Member whose identification cards are issued with this Agreement. In consideration of statements made in any required application and timely payment of Premiums, Passport agrees to provide the Covered Services as outlined in this Agreement.

Incorporation by Reference: This Agreement, amendments, and riders to this Agreement, the applicable Schedule of Benefits for this plan, and any application(s) submitted to the Marketplace and/or Passport to obtain coverage under this Agreement, including the applicable rate sheet for this product, are incorporated into this Agreement by reference, and constitute the entire legally binding contract between Passport and the Subscriber.

Contract Changes: No amendment, modification, or other change to this entire legally binding contract between Passport and the Subscriber shall be valid until approved by Passport and evidenced by a written document signed by an Executive Officer of Passport. No agent of Passport has the authority to change this Agreement and incorporated documents or to waive any of its provisions.

Time Zone: Except as otherwise expressly provided herein, all references to a specific time of day refer to the specific time of day in the Eastern time zone of the United States of America.

DEFINITIONS

Some words or terms in this Agreement may not have their usual meanings. Health plans often use these words in a specific way. If a word with a specialized meaning appears in only one section of this Agreement, it will be defined in that section. Words with special meanings used in any section of this Agreement are capitalized and are explained in this Definitions section.

Adverse Benefit Determination: A denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including those based on a determination of eligibility, application of utilization review, or Medical Necessity. This can include rescission of coverage and applicability of State or Federal Surprise Billing protections.

Affordable Care Act ("ACA"): The comprehensive health care reform law enacted in March 2010, also referred to as "PPACA" or "Obamacare."

Allowed Amount: The maximum amount that Passport will pay for a Covered Service, less any required Member Cost Sharing. The Allowed Amount would be determined using a different reimbursement measure depending on the circumstances applicable in Sections 1, 2 and 3 below (in each case, the "Allowed Amount"):

1. For Covered Services furnished by a Participating Provider: These services shall be reimbursed at the contracted rate with the Participating Provider for such Covered Services.
2. For certain Covered Services furnished by a Non-Participating Provider: Subject to exceptions expressly permitted by law, the services described below shall be reimbursed at the out-of-network rate, as that term is defined and determined under applicable federal law:
    - Emergency Services furnished by a Non-Participating Provider;
    - Post-Stabilization Services furnished by a Non-Participating Provider when such Covered Services are treated, for reimbursement purposes, as Emergency Services under applicable State or federal law;
    - Air ambulance services furnished by a Non-Participating Provider; and
    - Covered Services furnished by a Non-Participating Provider during a visit at a Participating Provider that is a hospital, critical access hospital, ambulatory surgical center, or other facility required by law.
3. For all other Covered Services furnished by a Non-Participating Provider in accordance with this Agreement: Except if otherwise expressly required by applicable law, these services shall be reimbursed at the lowest of (a) Passport's median contracted rate for such Covered Service(s), (b) 100% of the published Medicare rate for such Covered Service(s), (c) Passport's usual and customary method for determining payment for such Covered Service(s), or (d) a negotiated amount agreed to by the Non-Participating Provider and Passport.

Annual Out-of-Pocket Maximum (also referred to as "OOPM"): The most a Member must pay for Covered Services in a Plan year. After a Member spends this amount on Deductibles, Copayments, and Coinsurance, Passport pays 100% of the costs of Covered Services. Amounts the Subscriber or Dependents pay for services not covered by this Plan do not count towards the OOPM. The Schedule of Benefits may list an

OOPM amount for each individual enrolled under this Agreement and a separate OOPM amount for the entire family when there are two or more Members enrolled. When two or more Members are enrolled under this Agreement:

1. The individual OOPM will be met, with respect to the Member, when that person meets the individual OOPM amount; or
2. The family OOPM will be met when a Member's family's Cost Sharing adds up to the family OOPM amount.

Once the total Cost Sharing for the Member adds up to the individual OOPM amount, Passport will pay 100% of the charges for Covered Services for that individual for the rest of the calendar year if they remain enrolled in this Plan. Once the Cost Sharing for two or more family members adds up to the family OOPM amount, Passport will pay 100% of the charges for Covered Services for the rest of the calendar year for the Member and every Member of their family if they remain enrolled in this Plan.

Balance Bill or Balance Billing: When a Provider bills a Member for the difference between the Provider's billed charges amount and the Allowed Amount. A Passport Participating Provider is not permitted to balance bill a Member for Covered Services.

Child-Only Coverage: Coverage under this Agreement that is obtained by a responsible adult for the sole purpose of providing benefit coverage only to a child under the age of 21.

Coinsurance: The percentage of costs for Covered Services that a Member is responsible for. The Coinsurance amount is calculated as a percentage of the rates that Passport has negotiated with the Participating Provider. If applicable, Coinsurances are listed in the Schedule.

Complications of Pregnancy: A condition due to pregnancy, labor, and delivery that requires medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness or a non-emergency caesarean section are not complications of pregnancy.

Copayment: A fixed amount that the Member will pay for a Covered Service. If applicable, Copayments are listed in the Schedule of Benefits.

Cost Sharing: The portion of costs that a Member is responsible for paying out of their own pocket for Covered Services. Where required for Covered Services captured under the federal No Surprises Act, this amount will be calculated based on the Recognized Amount. Generally, this term includes Deductibles, Coinsurance, and Copayments, but it does not include Premiums, Balance Bill amounts for Non-Participating Providers, or the cost of non-covered services. Passport will accept premium and/or Cost Sharing payments made on behalf of Members by third parties to the extent permitted by law.

Covered Service or Covered Services: Medically Necessary services, including some medical devices, equipment, and prescription drugs, that Members are eligible to receive from Passport under this Plan, unless otherwise prohibited by federal or State Law.

Deductible: The amount Members pay for Covered Services before Passport begins to pay for Covered Services. To find out which Covered Services are subject to the Deductible and the Deductible amounts for the Member's Plan, please refer to the Schedule of Benefits.

Dependent: A Member who meets the eligibility criteria as a Dependent, as outlined in this Agreement.

Distant Site: This is the location where a physician or other licensed Provider delivering a professional service is physically located when providing the service through telemedicine.

Drug Formulary or Formulary: A list of prescription drugs this Passport Plan covers. The Drug Formulary also puts drugs in different Cost Sharing levels or tiers.

Durable Medical Equipment or DME: Equipment and supplies that a Provider orders for everyday or extended use. DME may include medically necessary oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

Emergency or Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in:

a. 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;
b. Serious impairment to bodily functions; or
c. Serious dysfunction of any bodily organ or part; or

With respect to a pregnant woman who is having contractions:

a. A situation in which there is inadequate time to affect a safe transfer to another hospital before delivery; or
b. A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Services: Services to evaluate, treat, or stabilize an Emergency Medical Condition. These services may be provided in a licensed emergency room or other facility that provides treatment of Emergency Medical Conditions.

Essential Health Benefits or EHB: A set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more.

Experimental or Investigational: Any medical service including procedures, medications, facilities, and devices that the FDA has not approved for treatment or therapeutic use in connection with underlying medical condition for which such procedure, medication, facility, or device was prescribed.

FDA: The United States Food and Drug Administration.

Health Benefit Exchange: A governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and helps residents of the State of Kentucky buy qualified health plan coverage from insurance companies or health plans such as Passport. The Health Benefit Exchange may be run as a state-based marketplace, a federally facilitated marketplace, or a partnership marketplace. For the purposes of this Agreement, the term refers to the Health Benefit Exchange operating in the State of Kentucky, however it may be organized and run.

Hospital: A legally operated facility, licensed by the State, with the principal purpose or function of providing medical or hospital care, medical education, or medical research.

Marketplace: A governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and assists residents of the State in purchasing qualified health plan coverage from companies or health plans, such as Passport. The Marketplace may be run as a state-based marketplace, a federally facilitated marketplace, or a partnership marketplace. For the purposes of this Agreement, the term refers to the Marketplace operating in the State, however it may be organized and run.

Medical Necessity or Medically Necessary: Health care services or supplies required for diagnosing or treating an illness, injury, condition, disease, or its symptoms, and that meet accepted medical standards.

Member: An individual who is eligible and enrolled under this Agreement, and for whom Passport has received applicable first Premium payment (binder). The term includes a Dependent and a Subscriber, unless the Subscriber is a responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a child under age 21. In such cases, the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member and will act as the legal representative of the Member under this Agreement but will not be considered a Member.

Mental Health Services: Medically Necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, and any associated federal or State Law.

Molina Healthcare of Kentucky Inc. (“Molina”): The legal corporation authorized in Kentucky as a health maintenance organization and contracted with the Marketplace. Molina Healthcare of Kentucky Inc. does business as “Passport by Molina Healthcare” (“Passport”).

Non-Participating Provider: A Provider that has not entered into a contract with Passport to provide Covered Services to Members.

Other Practitioner: Participating Providers who provide Covered Services to Members within the scope of their license but are not Primary Care Providers or specialists.

Out-of-Area Service: A service provided outside of the Service Area and is therefore not a Covered Service, except as otherwise stated in this Agreement.

Participating Provider: A Provider that is licensed or otherwise authorized to provide health care services. They have entered into network contracts with Passport and to provide Covered Services to Members.

Passport Agreement and Individual Policy: This document, which provides information about coverage under this Plan and is also referred to as the "Agreement."

Plan: Health insurance coverage issued to an individual and Dependents, if applicable, that providing benefits for Covered Services. Depending on the services, Member Cost Sharing may apply.

Post-Stabilization Services: Items and services furnished (regardless of the department of the hospital where it occurs) after the Member has been stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the visit during which Emergency Services were provided.

Primary Care Provider: A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), Certified Nurse Practitioner, clinical nurse specialist, or Physician Assistant, as allowed under State law and the terms of the Plan, who provides, coordinates, or assists a Member in accessing a range of health care services.

Prior Authorization: Approval from Passport that is needed before Members get a medical service or drug so that the medical service or drug is covered.

Provider (or Health Care Provider): Any health professional, Hospital, institution, organization, pharmacy, or individual that furnishes any health care services and is licensed or otherwise authorized to furnish such services under State Law. This includes: advanced practice registered nurse; chiropractors; dentists; facilities or services required to be licensed; home medical equipment and services providers; optometrists; pharmacists; physicians, osteopaths, or podiatrists; physician assistants; and other health care practitioners as authorized under State Law.

Recognized Amount: Where required by the federal No Surprises Act, means the amount on which Member Cost Sharing amounts are calculated for Covered Services that are captured under the federal No Surprises Act.

Schedule of Benefits: A detailed list of Covered Services, along with the associated Member Cost Sharing.

Service Area: The geographic region where Passport is authorized by the State to offer individual products through the Marketplace, enroll Members seeking coverage via the Marketplace, and deliver benefits through approved individual health plans sold through the Marketplace.

Specialist: A Provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or specific symptoms and conditions.

Stabilize: To stabilize means to provide such medical treatment of the Emergency Medical Condition as may be necessary to assure, within reasonable medical 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 a pregnant woman who is having contractions, to deliver (including the placenta).

State Law: The body of law in Kentucky encompassing the state's constitution, statutes, regulations, sub-regulatory guidance, directives from state regulatory agencies, and common law.

Substance Use Disorder: Services consistent with definitions in State Law for chemical dependency relating to an illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under chapter State Law and/or alcoholic beverages. It is further characterized by frequent or an intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially disrupted.

Urgent Care or Urgent Care Services: Immediate care for an illness, injury, or condition serious enough that a reasonable person would seek care promptly, but not so severe as to require emergency room care.

ENROLLMENT AND ELIGIBILITY

To access Covered Services an individual must be enrolled as a Member of this Plan. Enrollment requires meeting the eligibility criteria set by the Marketplace. Once the eligibility condition are met, Premiums are paid and Passport processes the enrollment, the individual becomes a Member of this Plan.

Open Enrollment Period: The Marketplace will establish an annual period during which eligible individuals can apply and enroll in a health plan for the upcoming year. The effective date of coverage will be either January 1st or a date determined by the Marketplace.

Special Enrollment Period: If an individual does not enroll during an Open Enrollment Period, they may be able to enroll during a Special Enrollment Period (SEP). To qualify for an SEP, an individual must experience certain life changes established by the Marketplace. These include:

- Loss of qualifying health coverage
- Changes in household (such as marriage, divorce, birth, or adoption)
- Changes in residence
- Release from incarceration,
- Pregnancy: A pregnant woman, and any individual who is eligible for coverage because of a relationship to a pregnant woman, may be able to enroll any time during the pregnancy.

The availability and duration of a Special Enrollment Period depend on the specific life event and may require documentation. The effective date of a Member's coverage will be determined by the Marketplace.

For more information about Open Enrollment and Special Enrollment Periods, please visit kynect.ky.gov.

Child-Only Coverage: Passport offers Child-Only Coverage for individuals under the age of 21, and a parent or legal guardian applies on behalf of the child. For more information regarding eligibility and enrollment, please contact the Marketplace.

Dependents: Subscribers enrolling during an Open Enrollment Period or Special Enrollment Period may also apply to enroll eligible individuals as Dependents. Dependents must meet Marketplace-established eligibility requirements and are subject to this Agreement's terms and conditions. Passport does not limit Dependent eligibility based on financial dependency, residency, student status, employment, eligibility for other coverage, or marital status. The following individuals are considered Dependents:

1. **Spouse:** The individual lawfully married to the Subscriber under State Law.
2. **Child or Children:** The Subscriber's sons, daughters, legally-adopted children, stepchildren, foster children, children for which the Subscriber is a court-appointed guardian, or any of their descendants, such as grandchildren. Each child is eligible seek enrollment as a Dependent until the age of 26.
3. **Child with a Disability:** A child who reaches age 26 can remain a Dependent if they meet the following criteria:

- The child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition; and
- The child is primarily dependent on the Subscriber for support and maintenance, regardless of age, if the Child is permanently and totally disabled.
- The child remains covered by Passport as long as they remain incapacitated and meet the above eligibility criteria.

4. **Domestic Partner:** An individual of the same or opposite sex who lives together and shares a domestic life with the Subscriber but isn't married or joined by a civil union to the Subscriber. The Domestic Partner must meet any eligibility and verification of domestic partnership requirements established by the Marketplace and State Law.

Adding New Dependents: An individual may become eligible to be a Dependent after the Subscriber's enrollment in this Plan. The eligible individual may be able to enroll as a Dependent in the Member's Plan. To do so, Members must contact the Marketplace and complete any required applications, forms, and provide the requested information for the Dependent. To enroll, a new Dependent, a Member's request must be submitted to the Marketplace within 60 days from the date when the Dependent became eligible to enroll in the Plan.

1. **Spouse:** A Spouse may be added as a Dependent if the Subscriber applies no later than 60 days after any event listed below:
   - Loss of minimum essential coverage, as defined by the Affordable Care Act
   - The date of marriage to the Subscriber
   - The Spouse gains status as a citizen, national, or lawfully present individual
   - The Spouse permanently moves into the Service Area.
2. **Children (Under 26 Years of Age):** Children may be added as a Dependent if the Subscriber applies no later than 60 days after any event listed below:
   - Loss of minimum essential coverage, as defined by the Affordable Care Act
   - Becomes a Dependent through marriage, birth, placement for adoption, placement in foster care, adoption, placement for adoption, child support, or other court order. Coverage will begin on the date of the filing of the petition for adoption or the filing of the application for appointment of guardianship.
   - The Child gains status as a citizen, national, or lawfully present individual
   - The Child permanently moves into the Service Area.
3. **Newborn Child:** A newborn child of a Subscriber is eligible as a Dependent at birth. A newborn is automatically covered for 31 days, including the date of birth. A newborn child is eligible to continue enrollment if they enroll with Passport within 60 days. Covered Services includes treatment for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Covered Services include a 100% human diet to supplement the mother's breast milk or donor milk with a milk fortifier if the diet is:
   - Prescribed for the prevention of necrotizing enterocolitis and associated comorbidities; and
   - Administered under the direction of a doctor.

"100% human diet" means supplementing the mother's expressed breast milk or donor milk with a milk fortifier. "Milk fortifier" means a commercially prepared human milk fortifier made from concentrated 100% human milk.

Please note: Claims for newborns for eligible Covered Services will be processed as part of the mother's claims. Any Deductible or Annual Out-of-Pocket Maximum (OOPM) amounts met through the processing of a newborn's claims will accrue as part of the mother's Deductible and OOPM.

Discontinuation of Dependent Coverage: Coverage for Dependent will be discontinued on:

- At 11:59 p.m. on the last day of the calendar year that the Dependent child attains age 26, unless the child has a disability and meets specified criteria (see Child with a Disability)
- The date a final decree of divorce, annulment or dissolution of marriage is entered between the Dependent Spouse and Subscriber
- The date a termination of the domestic partnership decree is entered between the Subscriber and Domestic Partner
- For Child-Only Coverage, at 11:59 p.m. on the last day of the calendar year in which the non-Dependent Member reaches the limiting age of 21. The Member and any Dependents may be eligible to enroll in other products offered by Passport through the Marketplace
- The date the Subscriber loses coverage under this Plan

Continued Eligibility: If a Member becomes ineligible for coverage under this Plan, Passport will send a written notice at least 30 days before the effective date when the Member's coverage will end. The Member has an option to appeal the loss of eligibility with the Marketplace.

PREMIUM PAYMENT

To begin and maintain coverage under this Plan, Passport requires Members to make monthly payments called Premium Payments or Premiums. Premiums for the upcoming coverage month is due no later than the 25th day of the current month (referred to as the "Due Date"). Passport will send the Subscriber written notice before the Due Date to let them know how much to pay for next month's coverage.

Advanced Premium Tax Credit (APTC): This is a tax credit that allows the Subscriber to reduce their monthly Premium in advance. Passport does not determine or provide these tax credits. Subscribers should contact the Marketplace to check if they qualify. If eligible, Subscribers can use the tax credit in advance to lower their Premium.

Payment: Passport accepts Premium Payments online, by phone, by mail, and through money order. Please refer to MyPassportPayment.com or contact Customer Support for further information. Premium Payments are not accepted at Passport office locations.

Third Party Payment of Premium and Cost Sharing: Premium payments from third parties, except those required by law or made by a person or entity indicated below may not be accepted:

1. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations or urban Indian organizations;
3. A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf;
4. Family of a Member; and
5. Religious institutions and other non-profits when criteria is met pursuant to Passport's policy.

Late Payment Notice: Passport will send a written notice to the Subscriber's address of record if full payment of the Premium is not received on or before the Due Date. These notifications will inform the Subscriber of the amount owed, include a statement that Passport will terminate the Agreement for nonpayment if the full amount owed is not received before the expiration of the Grace Period as described in the Late Payment Notice, and provide the exact time when the membership of the Subscriber and any enrolled Dependents will end if payment is not received timely.

Grace Period: The Grace Period is the time after the Premium Payment due date when the full payment hasn't been made. If a Subscriber has not paid the Premium Payment in full by the due date, they can do so during the Grace Period to avoid losing their coverage. The length of time for the Grace Period depends on whether the Subscriber receives an Advanced Premium Tax Credit (APTC).

- **Grace Period for Subscribers with APTC:** When a Subscriber receives APTC and misses the Premium Payment due date, Passport provides a three month consecutive Grace Period. It starts on the first day of the first month on which full Premium is not paid. During the Grace Period, Passport will pay all appropriate claims for Covered Services rendered to the Subscriber and their Dependents during the first month of the Grace Period and may pend claims for Covered Services in the second and third months of the Grace Period; Passport will terminate this Agreement as of 11:59 p.m. Eastern time on the last day of the first

month of the Grace Period if all past due Premiums are not paid by the end of the third month.

- **Grace Period for Subscribers without APTC:** When a Subscriber does not receive APTC and misses the Premium Payment due date, Passport provides a 30-day Grace Period. It starts on the first day of the first month for which full Premium is not paid. During this time, Passport pays all appropriate claims for Covered Services. Passport will terminate this Agreement as of 11:59 p.m. Eastern time on the last day of the Grace Period if all past due Premiums are not paid.

Termination Notification for Nonpayment: Passport will send written notice to the Subscriber, informing them that their coverage, as well as coverage for their Dependents, has been terminated due to nonpayment of Premiums. Members may appeal the termination decision by Passport. For more information on how to file an appeals, please visit PassportHealthPlan.com/Marketplace, check the Appeals and Grievances section of this Agreement, or contact Customer Support.

Reinstatement After Termination: Passport permits the reinstatement of Members, without a gap in coverage if the reinstatement corrects an erroneous termination or cancellation action and is approved by the Marketplace.

Re-enrollment After Termination for Nonpayment: If a Subscriber is terminated for nonpayment of Premium and wants to enroll with Passport for the following plan year during the Open Enrollment Period or a Special Enrollment Period, Passport may require the Subscriber to pay any past due Premiums. Passport will also require full payment for the first month's Premium before accepting the Subscriber's enrollment. If a Subscriber pays all past due Premiums, any eligible claims that were previously denied due to nonpayment will be reprocessed for payment.

Renewability of Coverage: Passport will continue coverage for Members on the first day of each month if all due Premiums have been received. Renewal is subject to Passport's right to make changes to this Agreement and the Member's ongoing eligibility for this Plan. Members must follow the procedures required by the Marketplace to redetermine eligibility and guaranteed renewability for enrollment every year during the Open Enrollment Period. If Passport exercise's the right not to renew coverage, it will not take effect until the renewal date occurring on, or after and nearest, the policy anniversary date and will not be based on any claim originating while this Plan is in effect.

TERMINATION OF COVERAGE

The termination date is the first day a former Member is no longer enrolled with Passport. Coverage for a former Member ends at 11:59 p.m. Eastern time on the day before the termination date. Passport will send notice of termination to the Member at least 30 days before the termination date, including the reason for termination. If Passport terminates a Member for any reason, the Member must pay all outstanding amounts related to their coverage with Passport, including Premiums, for the period before the termination date.

Unless there is fraud or intentional misrepresentation, if a Member's coverage is terminated, any Premium payments received on behalf of the terminated Member for periods after the termination date, minus any amounts owed to Passport or its Providers for Covered Services provided before the termination date will be refunded to the Subscriber within 30 days. Passport and its Providers will have no further liability or obligation under this Plan. In cases of fraud or intentional misrepresentation, Passport may retain portions of this amount to recover losses.

Passport may terminate or not renew a Member's coverage for any of the following reasons:

Ineligibility of Dependent and Child-Only Coverage Due to Age: When a Dependent no longer meets the age eligibility requirements for coverage set by the Marketplace and Passport, termination will occur. For further details on the effective date of termination, please refer to the "Discontinuation of Dependent Coverage" section.

Member Ineligibility: A Member no longer meets the eligibility requirements for coverage required by the Marketplace and Passport. The Marketplace will send the Member notification of their loss of eligibility. Passport will also send the Member written notification when informed that the Member no longer resides within the Service Area. Coverage will end at 11:59 p.m. on the last day of the month following the month in which either of these notices is sent to the Member. The Member may request an earlier termination effective date.

Nonpayment of Premium: Please refer to "Premium Payment" section.

Fraud or Intentional Misrepresentation: If a Member engages in fraudulent activity or intentionally mispresents a material fact related to their coverage, Passport will send written notice of rescission of coverage, and the Member's coverage will end at 11:59 p.m. Eastern time on the 30th day from the date notification is sent. Passport may refuse further enrollment from the Member and may report any suspected criminal acts to authorities. Members have the option to appeal the rescission of coverage.

Member Disenrollment Request: Members can request disenrollment through the Marketplace. Coverage will end 14 days after the Member provides notice of their request for disenrollment.

Discontinuation of a Particular Product: If Passport decides to stop offering a particular product in accordance with State Law, Passport will provide written notice of discontinuation at least 90 calendar days before coverage ends.

Discontinuation of All Coverage: If Passport decides to stop offering all health coverage in a State, in accordance with State Law, Passport will send Members written notice of discontinuation at least 180 calendar days before coverage ends.

CONTINUITY OF CARE

Members receiving an Active Course of Treatment (as defined below) for Covered Services from a Participating Provider whose participation with Passport is ending without cause may have a right to continue receiving Covered Services from that Provider until the Active Course of Treatment is complete or for 90 days, whichever is shorter, at in-network Cost Sharing. An Active Course of Treatment is defined as:

- An ongoing course of treatment for a “Life-Threatening Condition,” which is a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;
- An ongoing course of treatment for a “Serious Acute Condition,” which is a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, post-operative visits, or radiation therapy;
- An ongoing course of treatment for “Special Circumstances,” which includes a circumstance in which a covered person has a disability, a congenital condition, a life-threatening illness, or is past the twenty-fourth week of pregnancy where disruption of the covered person's continuity of care could cause medical harm;
- Treatment received during the second or third trimester of pregnancy through the postpartum period, or a course of treatment received at any stage of pregnancy that is related to a pregnancy;
- Any treatment being received for a terminal illness; or
- An ongoing course of treatment for a health condition for which a treating physician or health care Provider attests that discontinuing care by that physician or health care Provider would worsen the condition or interfere with anticipated outcomes.

Continuity of care will end when the earliest of the following conditions have been met:

- Upon successful transition of care to a Participating Provider, if the Member chooses to transition their care.
- Upon completion of the course of treatment prior to the 90th day of continuity of care
- Upon completion of the 90th day of continuity of care
- The Member has met or exceeded the benefit limits under their plan
- Care is not Medically Necessary
- Care is excluded from a Member’s coverage
- The Member becomes ineligible for coverage

Passport will provide Covered Services at in-network Cost Sharing for the specifically requested medical condition, up to the lesser of Passport’s Allowed Amount or an agreed upon rate for such services.

If Passport and the Provider are unable to settle on an agreed upon rate, the Member may be responsible to the Provider for any billed amounts that exceed Passport’s Allowed Amount. That amount would be in addition to any in-network Cost Sharing amounts that Members owe under this Agreement. In addition, any payment for the

amounts that exceed the previously contracted amount will not be applied to Member's Deductible or OOPM.

ACCESS TO CARE

For an Emergency, call 911. For an Emergency, Members may call an ambulance or go to any Emergency facility, even if it is a Non-Participating Provider or outside of the Service Area.

24-hour Nurse Advice Line: Registered Nurses are available 24 hours a day, 365 days a year to answer questions and help Members access care. The Nurse Advice Line phone number is (833) 644-1622.

Participating Provider Requirement: In general, a Member must receive Covered Services from a Participating Provider; otherwise, the services are not covered, the Member will be 100% responsible for payment to the Non-Participating Provider, and the payments will not apply to the Member's Deductible or OOPM. However, a Member may receive Covered Services from a Non-Participating Provider for the following:

- Emergency Services
- Post Stabilization Services, unless the Member waives Balance Billing protections
- Services by a Non-Participating Provider at a Participating Facility that is a hospital, ambulatory surgical center or other Participating Facility required by State Law, unless the Member waives Balance Billing protections
- Air ambulance services
- Services from a Non-Participating Provider that are subject to Prior Authorization
- Exceptions described below under the "No Participating Provider to Provide a Covered Service" section
- Exceptions described under the "Continuity of Care" section

To locate a Participating Provider, please refer to the Provider directory at PassportHealthPlan.com/Marketplace or call Customer Support. Because Non-Participating Providers are not in Passport's contracted Provider network, unless Balance Billing protections apply, they may Balance Bill Members for the difference between Passport's Allowed Amount and the rate that they charge.

When a Member demonstrates reliance on Passport's Provider directory as to the Participating Provider status of the provider or facility, and that information turns out to be incorrect, the Member's cost sharing will be limited to the amount that would have applied if the Non-Participating Provider or Non-Participating Facility was a Participating Provider. In this situation, the applicable Deductible or Annual Out-of-Pocket Maximum (OOPM), if any, would apply as if such services were furnished by a Participating Provider or a Participating Facility.

Member ID Card: Members should always carry their Member identification (ID) card with them. Members must show their ID card every time they receive Covered Services. For a replacement ID card, visit MyPassportHealthPlan.com or contact Customer Support. Digital versions of the ID card are available through MyPassportHealthPlan.com and the *My Molina* Mobile App.

Member Right to Obtain Healthcare Services Outside of Policy: Passport allows Members to seek healthcare services outside this Agreement on any terms or conditions they choose. However, Members will be fully responsible for payment for such services, and these payments will not count toward their Deductible or Annual Out-of-Pocket Maximum (OOPM) for services covered under this Agreement. For exceptions, Members should review the Covered Services section of the Agreement and refer to applicable Balance Billing protections provided by federal and State Law.

Primary Care Provider (PCP): A PCP handles routine and basic health care needs. PCPs offer services like physical exams, immunizations, and treatment for non-urgent health issues or injuries. Passport encourages Members to select a PCP from the Provider Directory. If a PCP is not selected, one will be assigned by Passport.

Members can request to change their PCP at any time through MyPassportHealthPlan.com or by contacting Customer Support. Changes made by the 25th of the month will be effective on the first day of the next calendar month. Changes made on or after the 26th of the month will take effect on the first day of the second calendar month.

Each family member can select a different PCP. A doctor who specializes in pediatrics may be selected as a child's PCP. A doctor who is an OB/GYN may be selected as a Member's PCP, with no referrals required. Sometimes a Member may not be able to select the PCP from the Provider Directory they want. This may happen because:

- The PCP is no longer a Participating Provider with Passport, or
- The PCP already has all the patients he or she can take care of right now.

Telehealth Services: Telehealth is a mode of delivering healthcare services through the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, treatment, and information across distance. Telehealth includes real-time interactive audio or video telecommunication technology or store-and-forward services that are provided via synchronous or asynchronous technologies, remote patient monitoring technology, and audio-only encounters, by a health care provider to a patient or to another health care provider at a different location. Covered Services are also available through Telehealth, except as specifically stated in this Agreement. Telehealth includes telepsychiatry and telehealth services provided by a home health agency licensed under KRS Chapter 216. In-person contact with a Provider is not required for these services, and the type of setting where these services are provided is not limited.

Telehealth services:

- Must be obtained from a Participating Provider licensed in Kentucky, or as allowed under the standards and provisions of a recognized interstate compact.
- Are meant to be used when care is needed now for non-Emergency medical issues.
- Are a method of accessing Covered Services, and not a separate benefit.
- Are not permitted when the Member and Participating Provider are in the same physical location.
- Do not include texting, facsimile, or email.

For Covered Services provided through store-and-forward technology, an in-person office visit is required to establish a diagnosis or treatment plan.

Non-Participating Provider to Provide a Covered Service: In the event that no Participating Provider is available to provide a non-Emergency, Medically Necessary Covered Service, Passport will arrange to provide the Covered Service through a Non-Participating Provider. The Covered Service will be provided in a manner consistent with, and at no greater cost than, the same Covered Service when delivered by a Participating Provider.

However, Prior Authorization is required before a Non-Participating Provider can initiate the service in this scenario.

Moral Objections: Some Participating Providers may object to providing some of the Covered Services under this Agreement. This may include family planning, contraceptive drugs, devices, and products approved by the FDA, including Emergency contraception, sterilization (including tubal ligation at the time of labor and delivery), pregnancy termination, and other services. Members should contact their Participating Providers or Customer Support to make sure they can get the healthcare services that they are seeking. Passport will assist Members to receive requested Covered Services rendered by other Participating Providers.

Accessing Care for Members with Disabilities: The Americans with Disabilities Act (ADA) prohibits discrimination based on disability and requires that Passport and its contractors make reasonable accommodations for Members with disabilities. To request reasonable accommodation assistance, Members with disabilities can contact Customer Support.

Physical Access: Every effort has been made to ensure that Passport's offices and the offices of Participating Providers are accessible to individuals with disabilities. Members with special needs should call Passport's customer support center at the number shown on the Welcome page of this Agreement for assistance finding an appropriate Participating Provider.

Access for the Deaf or Hard of Hearing: Call Customer Support at the TTY 711 number for assistance.

Access for Persons with Low Vision or Who Are Blind: This Agreement and other important product materials will be made available in accessible formats for persons with low vision or who are blind. Large print and enlarged computer disk formats are available. This Agreement is also available in an audio format. For accessible formats, or for direct help in reading the Agreement and other materials, please call Customer Support.

Disability Access Grievances: If a Member believes Passport or its doctors have failed to respond to their disability access needs, they may file a grievance with Passport. Please refer to the Appeals and Grievances section of this Agreement for information regarding how to file a grievance.

PRIOR AUTHORIZATION

Passport must approve certain medical services and prescription drugs before covering them. This process is referred to as Prior Authorization ("PA"). Many Covered Services can be received without the need for PA. When PA is necessary for a particular medical service or drug, the Member's Provider will initiate the PA request on their behalf.

For a comprehensive list of Covered Services and information about whether they require PA, please visit PassportHealthPlan.com/Marketplace. The list specifies which services require PA and which do not. Additionally, Members can reach out to Customer Support for assistance.

Passport reviews PA requests upon receiving all required information. In urgent cases, a Member's Provider may request expedited PA processing. Passport will communicate the decision to the Member's Provider within the timeframes allowed by federal and State Law.

Members will be notified if their PA request is denied, and they will receive information on how to appeal the denial.

Please note that PA rules are subject to change. Members are encouraged to contact Customer Support or visit PassportHealthPlan.com/Marketplace before seeking certain services.

Prior Authorization Timeframes

Medical Services:

- **Routine PA Requests:**
  - Within five (5) days from receipt of all information reasonably necessary and requested by Passport to make the determination.
- **Urgent PA Requests:**
  - Within twenty-four (24) hours from receipt of all information reasonably necessary and requested by Passport to make the determination.

The urgent timeframes apply if use of the standard ones:

- May seriously threaten your life or health.
- May seriously threaten your ability to regain full function.
- Would cause severe pain and cannot be managed without the requested care, according to your Provider.

- **Emergency Medical Conditions and Post-Stabilization Services:** Do not need PA. However, Post-Stabilization Services received in the inpatient department of a hospital are subject to the Inpatient Concurrent Review process discussed below.

Prescription Drugs and Medications: Prior Authorization decisions and notifications for access to medications not listed on the Passport Formulary will be provided as described in the section of this Agreement titled "Prior Authorization," "Access to Non-Formulary Drugs" or "Requesting a Formulary Exception."

Medical Necessity: Prior Authorization determinations are based on a review of Medical Necessity for the requested service. Passport is here to help guide Members throughout this process. If a Member has questions about how a certain service may be approved, they can visit PassportHealthPlan.com/Marketplace or contact Customer Support. Passport can explain how this type of decision is made.

The criteria for determining Medical Necessity for healthcare services include evaluating if the services align with the Member's diagnosis or condition concerning type, amount, frequency, level, setting and duration. The assessment of Medical Necessity is based on generally accepted medical and scientific evidence and consistent with generally accepted practice parameters.

Passport will not grant Prior Authorization if the necessary information for review is not provided. Services that do not meet the criteria for Medical Necessity will not receive approval. If the service requested is not a Covered Service, it will not be approved. Members will receive written notice explaining the reasons for the denial of the Prior Authorization request. The Member, Member's authorized representative, or their Provider can appeal the decision for Medical Necessity determination. The decision letter will inform Members of the process to appeal the denial decision. These instructions are also in the section of this Agreement titled "Grievances and Appeals." Members can request the clinical review criteria used for assessing Medical Necessity for authorization requests by contacting Customer Support.

If a Member or their Provider chooses to proceed with a service that has not been authorized by Passport, the Member will be responsible for covering the cost of those services.

Utilization Review: Licensed Passport staff processes Prior Authorization requests and conducts concurrent review. Upon request, Providers and Members requesting authorization for Covered Services will be provided the criteria used for making coverage determinations. Passport provides assistance and informs Members of alternatives for care when a member is not authorized for a service.

Concurrent Review: Passport conducts concurrent review on inpatient and outpatient cases.

- For non-Emergency admissions, a Member, their Provider, or the admitting facility should request precertification at least 14 days before the date the Member is scheduled to be admitted. This will allow time to request additional information if it is needed. Requests will be processed within five (5) days from receipt of all information reasonably necessary and requested by Passport to make the determination.
- For an Emergency admission, a Member, their Provider, or the admitting facility should notify Passport within 24 hours or as soon as reasonably possible after the Member has been admitted.
- For outpatient and inpatient non-Emergency medical services requiring Prior Authorization, a Member, their Provider, or the admitting facility should notify Passport at least 14 days before the outpatient care is provided, or the procedure is scheduled. This will allow time to request additional information if it is needed.

Requests will be processed within five (5) days from receipt of all information reasonably necessary and requested by Passport to make the determination.

Second Opinion: A Member's Provider may want another Provider to review a Member's condition, which is called a Second Opinion. This Provider may review the Member's medical record, set an appointment, and may suggest a plan of care. Passport only covers Second Opinions when furnished by a Participating Provider.

Failure to Approve or Deny: If Passport fails to make a Prior Authorization or Concurrent Review determination and provide written notice within the required time frames, the request shall be deemed to be a Prior Authorization for requested services. However, this does not apply where the failure to approve or deny a request or provide the notice results from circumstances which are documented to be beyond Passport's control.

COORDINATION OF BENEFITS (COB)

This provision applies when a person has health care coverage under more than one Plan. Plan is defined below. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

Definitions:

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   1) Plan includes: group and nongroup insurance contracts; Health Maintenance Organization (HMO) contracts; closed panel plans or other forms of group or group-type coverage (whether insured or self-insured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
   2) Plan does not include: medical benefits under group or individual motor vehicle “no fault” and traditional “fault” type contracts; hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by State Law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under (1) 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.

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies, and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determines whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan’s benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any Plan covering the person.

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

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

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 a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred Provider arrangements.

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

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

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

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

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
D. Each Plan determines its order of benefits using the first of the following rules that apply:
    1. Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a Dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
    2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:
        a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married: The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
        b. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married: (a) If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree; (ii) If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits; (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or (iv) If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            - The Plan covering the Custodial parent;
            - The Plan covering the spouse of the Custodial parent;
            - The Plan covering the non-custodial parent; and then
            - The Plan covering the spouse of the non-custodial parent.

c. For a Dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a Dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan:

A. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.
B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

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. Passport may get the facts it needs from or

give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. Passport need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Passport any facts it needs 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, Passport 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. Passport 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. If the amount of the payments made by Passport is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services

COST SHARING

Passport requires Members to pay Cost Sharing for certain Covered Services under this Agreement. Members should review their Schedule of Benefits for all applicable Cost Sharing for Covered Services. For certain Covered Services, such as laboratory and X-rays that are provided on the same date of service and in the same location as an office visit to a PCP or a Specialist, Members will only be responsible for the applicable Cost Sharing amount for the office visit.

Members receiving covered inpatient Hospital or skilled nursing facility services on the effective date of this Agreement pay the Cost Sharing in effect for this Agreement upon the effective date of coverage with Passport. For items ordered in advance, Members pay the Cost Sharing in effect for this Agreement upon the effective date, for Covered Services only. Cost sharing for covered prescription drugs is due at the time the network pharmacy dispenses the Member's prescription. Formulary tiering and plan design Cost Sharing are described in the "Prescription Drugs" section of this Agreement and Schedule of Benefits for your plan.

COVERED SERVICES

This section describes the Covered Services available with this Plan. Covered Services are available to current Members and are subject to Cost Sharing, exclusions, limitations, authorization requirements, approvals and the terms and conditions of this Agreement. Passport will provide a Covered Service only if all of the following conditions are satisfied:

- The individual receiving Covered Services on the date the Covered Services are rendered is a Member;
- The Covered Services are Medically Necessary and/or approved by Passport;
- The services are identified as Covered Services in this Agreement;
- The Member receives Covered Services from a Participating Provider, except for Covered Services that are expressly covered when rendered by non-Participating Providers under the terms of this Agreement.

Passport will not cover any services, supplies, or equipment that are either provided prior to the effective date or after the termination date of this Agreement. Members should read this Agreement completely and carefully to understand their coverage and to avoid being financially responsible for services that are not covered under this Agreement.

Essential Health Benefits: Covered Services for Members include Essential Health Benefits (EHB), as defined by the Affordable Care Act (ACA) and its corresponding federal regulations, as well as State Law. Services that are not EHBs will be specifically described in this Agreement. EHB coverage includes at least the 10 categories of benefits identified in the ACA and Federal regulations. Members cannot be excluded from coverage in any of the 10 EHB categories. Please note, Members will not be eligible for EHB pediatric Covered Services under this Agreement as of 11:59 p.m. on the last day of the month that they turn age 21. This includes pediatric dental coverage that can be purchased separately through the Marketplace and pediatric vision coverage.

Under the ACA and its corresponding federal regulations governing EHBs:

- Passport is not allowed to set lifetime limits or annual limits on the dollar value of EHBs provided under this Agreement.
- When EHB preventive services are provided by a Participating Provider, the Member will not have to pay any Cost Sharing.
- Passport must ensure that the Cost Sharing that Members pay for all EHBs does not exceed an annual limit determined under the ACA.

For the purposes of this EHB annual limit, Cost Sharing refers to any costs that a Member is required to pay for EHBs. Cost Sharing includes Deductibles, Coinsurance and Copayments, but excludes Premiums and Member spending on non-Covered Services.

Approved Clinical Trials: Passport covers routine patient care costs for qualifying Members participating in Approved Clinical Trials for cancer and/or another life-threatening disease or condition. A Life-Threatening Disease or Condition means any disease or condition from which the likelihood of death is probable unless the course of

the disease or condition is interrupted. Members will never be enrolled in a clinical trial without their consent.

To qualify for coverage, an enrolled Member must be diagnosed with cancer or other life-threatening disease or condition, be accepted into an Approved Clinical Trial (as defined below), and have received Prior Authorization or approval from Passport. An Approved Clinical Trial means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and:

1. The study is approved or funded by one or more of the following: the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, the U.S. Department of Defense, the U.S. Department of Veterans Affairs, or the U.S. Department of Energy, the U.S. Food and Drug Administration, or a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants or
2. The study or investigation is conducted under an investigational new drug application reviewed by the FDA, or
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Specifically, the clinical trial must do one of the following: (1) test how to administer a health care service, item, or drug for the treatment of cancer; (2) test responses to a health care service, item, or drug for the treatment of cancer; (3) compare the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer; or (4) study new uses of health care services, items, or drugs for the treatment of cancer.

All approvals and Prior Authorization requirements that apply to routine care for Members not in an Approved Clinical Trial also apply to routine care for Members in Approved Clinical Trials. If a Member qualifies, Passport cannot deny their participation. Additionally, Passport cannot deny, limit, or place conditions on its coverage of Member's routine patient costs associated with their participation in an Approved Clinical Trial for which they qualify. Members will not be denied or excluded from any Covered Services under this Agreement based on their health condition or participation in an Approved Clinical Trial. The cost of medications used in the direct clinical management of the Member will be covered unless the Approved Clinical Trial is for the investigation of that drug or the medication is typically provided free of charge to Members in the clinical trial.

Passport does not have an obligation to cover certain items and services that are not routine patient costs, as determined by the Affordable Care Act or Kentucky law, even when the Member incurs these costs while in an Approved Clinical Trial. Costs excluded from coverage under this Plan include:

1. the investigational item, device or service itself,
2. items and services solely for data collection and analysis purposes and not for direct clinical management of the patient,
3. any service inconsistent with the established standard of care for the patient's diagnosis, and

4. transportation, lodging, food, and other expenses associated with the travel to or from a Facility providing the Approved Clinical Trial.

Services or routine patient costs associated with Approved Clinical Trials obtained from a Non-Participating Provider are not covered.

If one or more Participating Providers are taking part in an Approved Clinical Trial, Passport may require that a Member participate in the trial through such Participating Provider as long as the Provider accepts the Member as a participant in the Approved Clinical Trial.

If the Approved Clinical Trial is being conducted outside the Member's state of residence, coverage for routine patient services related to the Approved Clinical Trial will not be denied solely because the trial is conducted out-of-state.

All approvals and Prior Authorization requirements that apply to routine care for Members not in an Approved Clinical Trial also apply to routine care for Members in Approved Clinical Trials. For Covered Services related to an Approved Clinical Trial, Cost Sharing will apply as if the service were not specifically related to an Approved Clinical Trial. Members will pay the Cost Sharing they would pay if the services were not related to a clinical trial. Members should contact Customer Support for further information regarding coverage.

Autism Spectrum Disorder (ASD): Passport covers the diagnosis and treatment of autism spectrum disorders including autistic disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified, as defined by the Diagnostic and Statistical Manual of Mental Disorders ("DSM"), current edition. Passport covers treatment for autism spectrum disorders, including Applied Behavioral Analysis (ABA), prescribed or ordered by a Provider. Case Management will act as a liaison to facilitate communications between the Member and Passport. For more information regarding these services, please contact Case Management.

Treatment for autism spectrum disorders includes the following care for an individual diagnosed with any of the autism spectrum disorders:

- Medical care services provided by a licensed physician, an advanced registered nurse practitioner, or other licensed health care provider;
- Habilitative or rehabilitative care, including professional counseling and guidance services, therapy, and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual;
- Pharmacy care, if covered by the plan, including medically necessary medications prescribed by a licensed physician or other health-care practitioner with prescribing authority and any medically necessary health-related services to determine the need or effectiveness of the medications;
- Psychiatric care, including direct or consultative services, provided by a psychiatrist licensed in the state in which the psychiatrist practices;
- Psychological care, including direct or consultative services, provided by an individual licensed by the Kentucky Board of Examiners of Psychology or by the appropriate licensing agency in the state in which the individual practices;

- Therapeutic care services provided by licensed speech therapists, occupational therapists, or physical therapists; and
- Applied behavior analysis (ABA) prescribed or ordered by a licensed health or allied health professional.

Cancer Treatment: Passport provides the following coverages for cancer care and treatment, including:

- Preventive cancer screening and testing (please refer to the Preventive Services section of this Agreement for more information)
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the Reconstructive Surgery and Prosthetic and Orthotic Devices sections of this Agreement for more information)
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial section of this Agreement for more information)
- Prescription medications to treat cancer (please refer to the Prescription Drug section of this Agreement for more information)
- High-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation, according to guidance from the American Society for Blood Marrow Transplantation or the International Society of Hematotherapy and Graft Engineering, whichever has the higher standard
- Mammogram services, including both diagnostic breast examinations and supplemental breast examinations using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound (without Member Cost Sharing).
    - Diagnostic breast examination means a Medically Necessary and appropriate examination of the breast that is used to evaluate an abnormality seen or suspected from, or detected by, a screening examination for breast cancer or another means of examination.
    - Supplemental breast examination means a Medically Necessary and appropriate examination of the breast that is: (1) used to screen for breast cancer when there is no abnormality seen or suspected and (2) based on personal or family medical history, or additional factors, that may increase the individual's risk of breast cancer.

Dental and Orthodontic Services: Dental and orthodontic services provided under this agreement must be Prior Authorized and are limited to the following:

- Dental anesthesia when medically necessary
    - This includes coverage for anesthesia and Hospital or Facility charges for services performed in a Hospital and Ambulatory Surgical Facility. These services must be in connection with dental procedures for Members who are either below the age of nine years, have serious mental or physical conditions, or have significant behavioral problems. The admitting Physician or dentist must certify that, because of the patient's age,

condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures. Benefits are not provided for routine dental care.

- Dental and Orthodontic services for cleft palate
- Services to treat Temporomandibular Joint Syndrome (TMJ) (Please refer to the Temporomandibular Joint Syndrome section of this Agreement for more information)
- Dental services needed due to accidental injury when all of the following are true:
    - Treatment is necessary because of accidental damage.
    - Dental services are received from a Doctor of Dental Surgery, Doctor of Medical Dentistry or a Physician who acts within the scope of his or her license.
    - The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (A Member may request an extension of this time period provided that they do so within 60 days of the injury and if extenuating circumstances exist due to the severity of the injury.)

    Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

    - Dental services to repair damage caused by accidental injury must conform to the following time-frames:
        - Treatment is started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
        - Treatment must be completed within 12 months of the accident.

    - Benefits for treatment of accidental Injury are limited to the following:
        - Emergency examination.
        - Necessary diagnostic X-rays.
        - Endodontic (root canal) treatment.
        - Temporary splinting of teeth.
        - Prefabricated post and core.
        - Simple minimal restorative procedures (fillings).
        - Extractions.
        - Post-traumatic crowns if such are the only clinically acceptable treatment.
        - Replacement of lost teeth due to the Injury by implant, dentures, or bridges.

Passport does not provide pediatric dental services under this Agreement.

Diabetes Services: Passport covers the following diabetes related services:

- Diabetes self-management training and education when provided by a Participating Provider.
- Diabetic eye examinations (dilated retinal examinations).

- Easy to read diabetic health education materials.
- Medical nutrition therapy in an outpatient, inpatient or home health setting.
- Outpatient self-management training.
- Routine foot care for Members with diabetes (including for care of corns, bunions, calluses, or debridement of nails).
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider who is a podiatrist.
- Preventive Services including:
    - Diabetes (Type 2) screening
    - Screening for gestational diabetes
- Nutritional counseling.
    - Coverage is limited to nutritional education required for a disease in which patient self-management is an important component of treatment and there is a knowledge deficit regarding the disease which requires the intervention of a trained health professional; inborn errors of metabolism; or genetic conditions.

For information regarding diabetes supplies, please refer to the “Prescription Drug” section.

Dialysis Services: Passport covers acute and chronic dialysis services if all the following requirements are met:

- The services are provided by a Participating Provider; and
- The Member satisfies all medical criteria developed by Passport.

Emergency Services: Emergency Services are available 24 hours a day, 7 days a week for Members. Members who think they are having an Emergency should call 911 right away and go to the closest Emergency facility. When receiving Emergency Services, Members should bring their Member ID card. Members who do not believe they need Emergency Services, but who need medical help, should call the 24-hour Nurse Advice Line toll-free or contact their PCP. Members should not go to an Emergency room if the condition is not an Emergency.

Emergency Services When Out of Service Area: Members should go to the nearest Emergency room for care when outside the Passport Service Area when they think they are having an Emergency. Please contact Customer Support within 24 hours or as soon as possible.

Emergency Services by a Non-Participating Provider: Emergency Services for treatment of an Emergency Medical Condition are subject to Cost Sharing for both Emergency Services provided by Participating Providers or Non-Participating Providers. Members should refer to the Cost Sharing for Emergency Services in the Schedule of Benefits.

Important: Except as otherwise required by State Law, when Emergency Services are received from Non-Participating Providers for the treatment of an Emergency Medical Condition, claims for Emergency Services will be paid at Passport’s Allowed Amount. Passport may not deny emergency department services and alter the level of coverage

or cost-sharing requirements for any condition or conditions that constitute an emergency medical condition as defined by Kentucky law.

Transfer to a Participating Provider Hospital: Prior Authorization is required to get Hospital services, except in the case of Emergency Services, and other exceptions identified in this Agreement. For Members who are admitted to a Non-Participating Provider facility for Emergency Services, Passport will work with the Member and their Provider to provide transportation to a Participating Provider facility. If the Member's coverage terminates during a Hospital stay, the services received after the termination date are not Covered Services. If the Member waives Federal Balance Billing protections and refuses the transfer, additional services provided in the Non-Participating Provider facility are not Covered Services. The Member will be 100% responsible for payments, and the payments will not apply to the Annual Maximum Out-of-Pocket.

Emergency Medical Transportation: Emergency Medical Transportation (ground and air ambulance), or ambulance transport services provided through the 911 emergency response system are covered when Medically Necessary. These services are covered only when other types of transportation would put the Member's health or safety at risk. Members may be responsible for charges that exceed the Allowed Amount covered under this benefit for emergency medical transportation (ground ambulance) services rendered by a Non-Participating Provider.

Family Planning: Passport covers family planning services, including all methods of birth control approved by the FDA. Family planning services include:

- Diagnosis and treatment of sexually transmitted diseases (STDs) if medically indicated.
- Prescription birth control supplies, including emergency birth control supplies when filled by a Participating Provider pharmacist, or by a Non-Participating Provider in the event of an Emergency.
- Follow-up care for any problems Members may have using birth control methods issued by the family planning Providers.
- Laboratory tests if medically indicated as part of deciding what birth control methods a Member might want to use.
- Pregnancy testing and counseling.
- Screening, testing and counseling of at-risk individuals for HIV and referral for treatment.
- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males).
- Any other outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain or remove a contraceptive.

Habilitation Services: Passport covers healthcare services and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. These include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Habilitation Services include:

- Physical therapy (25 visit limit per calendar year)

- Speech therapy (25 visit limit per calendar year)
- Occupational therapy (25 visit limit per calendar year)

Home Healthcare: Passport covers home healthcare services on a part-time, intermittent basis to a Member confined to his or her home due to physical illness – when Prior Authorized and provided by a contracted home healthcare agency. Passport covers the following home healthcare services:

- In-home medical care services
- Home health aide services
- Medical social services
- Medical supplies
- Necessary medical appliances
- Nurse visits and part-time skilled nursing services
- Physical, occupational, speech or respiratory therapy

The following home healthcare services are covered:

- Up to 100 visits per calendar year (counting all home health visits, except private duty nursing visits). At least four (4) hours of home health aide service shall be considered as one (1) home health visit.
- Up to 4 hours per visit by a nurse, medical social worker, physical, occupational, or speech therapist. At least four (4) hours of home health aide service shall be considered as one (1) home health visit.

Passport also covers private duty nursing if such services are certified by the Member's PCP initially and every two weeks thereafter, or more frequently if required by Passport for Medical Necessity review. There is a limit of 250 visits per calendar year for such private duty nursing services in the home. Members must have Prior Authorization for home healthcare services after the first 6 visits for outpatient and home settings. Services must be billed by a Home Healthcare Participating Provider agency.

Hospice Services: Passport covers hospice services for Members who are terminally ill (a life expectancy of 6 months or less). Members can choose hospice care instead of the traditional services covered by this Plan. Covered services for hospice care will not be less than the hospice care benefits provided by Medicare.

Inpatient Hospital Services: Members must have a Prior Authorization before receiving covered hospital services, except in the case of Emergency and other exceptions identified in this Agreement. Post-Stabilization Services received in a Non-Participating hospital after admission to the hospital for Emergency Services, will be covered provided the services are authorized, the Member's coverage with Passport has not terminated, and the Member has not waived Balance Billing protections pursuant to federal or State Law. Passport will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Passport terminates during a hospital stay, the services received after the Member's termination date are not Covered Services.

Medically Necessary inpatient services are generally and customarily provided by acute care general hospitals inside the Service Area. Non-Covered services include private duty nursing, guest trays, and patient convenience items. Inpatient Rehabilitative Services are limited to 60 days per calendar year.

Laboratory Tests, Radiology (X-Rays), and Specialized Scanning Services: Passport covers laboratory, radiology (including X-ray) and scanning services at a Participating Provider. Covered scanning services can include CT Scans, PET Scans and MRI with Prior Authorization. Passport can assist Members select an appropriate facility for these services. Limited coverage for Medically Necessary dental and orthodontic X-rays is outlined in the Dental and Orthodontic Services section of this Agreement.

Passport will also cover genetic tests for cancer risk which are recommended by a physician, physician assistant, genetic counselor, or advanced practice registered nurse. You will not be required to pay a co-pay or deductible for a genetic cancer risk test.

Passport will cover colorectal cancer examinations and laboratory tests without co-pay or deductible.

Passport will also cover bone density testing for women age thirty-five (35) years and older, to obtain baseline data for the purpose of early detection of osteoporosis.

Passport will cover biomarker testing when ordered by a qualified health care provider operating within the provider's scope of practice for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of an insured's disease or condition when the test is supported by medical and scientific evidence.

Mental Health Services (Inpatient and Outpatient): Passport covers a continuum of Mental Health Services when provided by Participating Providers and facilities acting within the scope of their license. Passport also covers Mental Health Services for Emergency Services and Post Stabilization Services when provided by Participant and Non-Participant Providers. Passport covers the diagnosis or treatment of mental disorders, including services for the treatment of gender dysphoria to the extent required by federal and State law. Passport may require authorization for coverage of services, including inpatient and certain outpatient services. The concurrent review authorization process applies to all involuntary admission. See the “Inpatient Concurrent Review” section of this Agreement for more information.

A mental disorder is a mental health condition or substance abuse disorder identified in the Diagnostic and Statistical Manual of Mental Disorders, current edition, Text Revision (DSM). The mental disorder must result in clinically significant distress or impairment of mental, emotional, or behavioral functioning. Mental disorders covered under this Agreement include severe mental illness of a person of any age. Severe mental illness includes the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, anorexia nervosa, or bulimia nervosa.

Passport does not cover career, marriage, parental or job counseling or therapy. In addition, treatment or testing within an inpatient setting related to Pervasive Developmental Disorders, including autism spectrum disorder, learning disabilities, and/or cognitive disabilities are not covered. Passport does not cover services for mental health conditions that the DSM identifies as something other than a Mental Disorder.

Passport generally covers the following Medically Necessary Mental Health Services:

- Inpatient care
- Crisis stabilization
- Short-term residential treatment services
- Partial hospitalization programs for mental health
- Intensive outpatient programs for adults and day treatment for children
- Psychological and neuropsychological testing
- Behavioral health procedures
- Individual and group psychological therapy

Mental Health Parity and Addiction Equity Act: Passport complies with the Mental Health Parity and Addiction Equity Act and similar State Law. Passport ensures that the financial requirements and treatment limitations on Mental Health Services or Substance Use Disorder benefits provided are no more restrictive than those on medical or surgical benefits.

Physician Services: Passport covers the following outpatient physician services including:

- Office visits, including:
    - Associated medical supplies
    - Pre-natal and post-natal visits
- Chemotherapy and other Provider-administered drugs whether administered in a physician's office, an outpatient or an inpatient setting
- Diagnostic procedures, including colonoscopies; cardiovascular testing, including pulmonary function studies; and neurology/neuromuscular procedures
- Radiation therapy
- Routine pediatric and adult health exams
- Injections, allergy tests and treatment
- Routine examinations and prenatal care provided by an OB/GYN. Members may select an OB/GYN as their PCP. Dependents have direct access to obstetrical and gynecological care. Primary care physicians may also refer you to an OG/GYN provider.
- Sleep studies (separate facility Cost Sharing may apply)

Pregnancy and Maternity: For prenatal care, Members may choose any Passport Participating Provider who is either an obstetrician/gynecologist (OB/GYN), certified nurse midwife, or nurse practitioner who is trained in women's health. Passport covers the following maternity care services:

- Outpatient maternity care including Medically Necessary supplies for a home birth;
- Services for complications of pregnancy, including fetal distress, gestational diabetes and toxemia;

- Routine nursery care for a newborn;
- Services following a miscarriage;
- Laboratory services; and
- Inpatient hospital care for 48 hours after a normal vaginal delivery or 96 hours following a delivery by Cesarean section (C-section). Longer stays require that Members or Member's Provider notifies Passport.

After talking with a Member, if the Member's Provider decides to discharge the Member and their newborn before the 48- or 96-hour period, Passport will cover post discharge services and laboratory services. Coverage for a length of stay begins at the time of delivery, if delivery occurs in a Hospital, or at the time of admission in connection with childbirth if delivery occurs outside of a Hospital. Preventive, primary care, and laboratory services will apply to post discharge services, as applicable. Passport does not cover services for anyone in connection with a surrogacy arrangement.

Pregnancy Termination: Passport covers pregnancy termination services only to the extent required by federal law, and by any State law. Passport does not cover an elective abortion. Elective abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

Note: Pregnancy termination services that are provided in an inpatient hospital setting require Prior Authorization.

Preventive Services: In accordance with the Affordable Care Act and as part of Member's Essential Health Benefits, Passport covers preventive services at no Cost Sharing for Members. Preventive services include:

- Those evidenced-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 (USPSTF). Please visit the USPSTF website for preventive services recommendations at: uspreventiveservicestaskforce.org;
- Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- With respect to infants, children, and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to women, those preventive services and screenings provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.
- Pre-exposure prophylaxis (PrEP) for the prevention of HIV infection for people at high risk of infection without cost-sharing. This includes:
    - PrEP medication (antiviral drugs when prescribed to prevent HIV infection)
    - Laboratory tests and other diagnostic procedures (including testing for HIV, sexually transmitted infections, renal functionality, Hepatitis B, Hepatitis C, and lipid panel)
    - Counseling about antiretroviral medication adherence

Passport provides coverage for colorectal cancer examinations as recommended by the American Cancer Society and the United States Multi-Society Task Force on Colorectal Cancer guidelines. Coverage includes all FDA-approved bowel preparation prescribed in connection with a colorectal cancer examination or laboratory test.

Passport provides coverage for contraceptive services, including emergency contraception, insertion/extraction of contraceptive devices, prescription-based sterilization procedures for women and tubal ligation. Coverage is not provided for the reversal of sterilization procedures.

Coverage is provided for breastfeeding support, supplies, counseling and includes the purchase of personal-use electric breast pump, one pump per birth. In the event of multiple births, only one pump is covered. This coverage includes the necessary supplies for the pump to operate.

All preventive services must be furnished by a Participating Provider to be covered under this Agreement. Office visits associated with preventive services are covered at no Cost Sharing when the service is not billed separately (or is not tracked as individual encounter data separately) from the office visit, and the primary purpose of the office visit is the delivery of the recommended preventive service.

As new recommendations and guidelines for preventive services are published and recommended by the government agencies identified above, they will become covered under this Agreement. Coverage will start for product years that begin one year after the date the recommendation or guideline is issued or on such other date as required by the ACA and its implementing regulations. The Plan year, also known as a policy year for the purposes of this provision, is based on the calendar year.

If an existing or new government recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a preventive service, then Passport may impose reasonable coverage limits on such preventive care. Coverage limits will be consistent with the ACA, its corresponding federal regulations and applicable State Law.

Prosthetic, Orthotic, Internal Implanted and External Devices: Passport covers the internal and external devices listed below. Prior Authorization is required.
Internally implanted devices:

- Cochlear implants
- Hip joints
- Intraocular lenses
- Osseointegrated hearing devices
- Pacemakers
- Hearing aids

External Devices:

- Artificial limbs needed due to loss resulting from disease, injury or congenital defect.
- Custom made prosthesis after mastectomy and four (4) surgical bras per Benefit Year, as required by the Women's Health and Cancer Rights Act.

- Podiatric devices to prevent or treat diabetes-related complications
- Wigs (the first one following cancer treatment, not to exceed one (1) per Benefit Year)

Coverage is dependent on all the following requirements being met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes.
- The device is the standard device that adequately meets the Member's medical needs.
- The Member receives the device from the Provider or vendor that Passport selects.

Prosthetic and orthotic device coverage includes services to determine whether the Member needs a prosthetic or orthotic device, fitting and adjustment of the device, repair or replacement of the device (unless due to loss or misuse). Covered Services are limited to a single purchase of each type of prosthetic device every 3 years. Passport a does not cover orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces. However, braces that stabilize an injured body part and braces to treat curvature of the spine are covered.

Reconstructive Surgery: Passport covers the following reconstructive surgery services when Prior Authorized:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function.
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.

The following reconstructive surgery services are not covered:

- Surgery that, in the judgment of a Participating Provider specializing in reconstructive surgery, offers only a minimal improvement in appearance
- Surgery that is performed to alter or reshape normal structures of the body to improve appearance

Rehabilitation Services: Passport covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. Rehabilitation Services include:

- Physical therapy (25 visit limit per calendar year)
- Occupational therapy (25 visit limit per calendar year)
- Speech therapy (25 visit limit per calendar year)
- Pulmonary rehabilitation (25 visit limit per calendar year)
- Cardiac rehabilitation (36 visit limit per calendar year)

- Manipulation therapy (20 visit limit per calendar year)
- Post-Cochlear Implant Aural Therapy (30 visit limit per calendar year)
- Cognitive Rehabilitation Therapy (20 visit limit per calendar year)
- Inpatient Rehabilitative Services (60 day limit per calendar year)

Routine Adult Dental Services (age 21 and older): Adult routine dental services are available on some Passport plans. Refer to the Member's Schedule of Benefits to confirm dental coverage and Cost Sharing for services covered with the plan. The following routine adult dental services are Covered Services for Members age 21 and older when provided by a Participating Provider.

Passport covers the following diagnostic services, preventive services, and special consultations when Medically Necessary:

- Diagnostic services including procedures to aid the Participating Provider in determining required dental treatment.
- Preventive services including cleanings, scaling in presence of generalized moderate or severe gingival inflammation - full mouth (please note: periodontal maintenance is considered to be a basic service for Cost Sharing purposes).
- Specialist consultation opinion or advice requested by a general dentist.

Passport covers the following basic dental services when Medically Necessary:

- General ; 5;esia or IV sedation when administered by a Participating Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
- Periodontal cleanings for periodontal maintenance.
- Palliative emergency treatment to relieve pain.
- Restorative services including amalgam and resin-based composite restorations (fillings) and prefabricated restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

Passport covers the following major dental services when Medically Necessary:

- Crowns and inlays/onlays, including treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
- Prosthodontics procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and implant supported prosthetics, including implant repair and recementation.
- Oral surgery for extractions and certain other surgical procedures (including pre- and post-operative care).
- Endodontics for the treatment of diseases and injuries of the tooth pulp.
- Periodontics for the treatment of gums and bones supporting teeth.
- Denture repair to partial or complete dentures, including rebase procedures and relining.

Note on additional Covered Services during pregnancy: When a Member is pregnant, Passport will pay for additional services to help improve the oral health of the Member during the pregnancy. The additional services that are available each Calendar Year while the Member is covered under the Policy include:

- One (1) additional oral exam, and either:

- One (1) additional routine cleaning;
- One (1) additional periodontal scaling and root planing per quadrant; or
- One (1) additional periodontal maintenance procedure.

Written confirmation of the pregnancy must be provided by the Member or the Member's Provider when the claim is submitted.

Exclusions and Limitations: Certain dental services are excluded or have limited coverage under all Passport plans, including those with coverage for routine adult dental services. These exclusions and limitations apply regardless of whether the services are within the scope of a Provider's license. Specific dental services have limited coverage under this plan and are outlined below:

- "**Optional Services**" - Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards . Optional Services also include the use of specialized techniques instead of standard procedures.
  Examples of Optional Services:
  - A composite restoration instead of an amalgam restoration on posterior teeth;
  - A crown where a filling would restore the tooth;
  - An inlay/onlay instead of an amalgam restoration; or
  - Porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown).

  If a Member receives Optional Services, an alternate Benefit will be allowed, which means Passport will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the optional service.The Member will be responsible for the difference between the higher cost of the optional service and the lower cost of the customary service or standard procedure.
- If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Agreement. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.
- Passport will pay for oral examinations (except after hours exams and exams for observation) no more than one (1) every six (6) months in a calendar year.
- Passport will pay for cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (including periodontal maintenance or any combination thereof) no more than one (1) every six (6) months in a calendar year. A full mouth debridement is allowed once in a lifetime, when the Member has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three (3) years, and counts toward the cleaning frequency in the year provided. Note that periodontal maintenance, procedure codes that include periodontal maintenance, and full mouth debridement are covered as a basic benefit, and routine cleanings

including scaling in presence of generalized moderate or severe gingival inflammation are covered as a diagnostic and preventive benefit. See note on additional Covered Services during pregnancy.

- A dental caries (tooth decay) risk assessment is allowed once in 12 months.
- Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.
- Application of caries arresting medicament is covered once per tooth every six (6) months when the Member has a caries risk assessment and documentation with a finding of high risk.
- Image limitations, including:
    - Passport will limit the total reimbursable amount to the Allowed Amount for a comprehensive series of radiographic images when the fees for any combination of intraoral images in a single treatment series meet or exceed the accepted fee for a comprehensive intraoral series.
    - Benefits are limited to either one (1) comprehensive intraoral series or one (1) panoramic image once every 60 months.
    - If a panoramic image is taken in conjunction with an intraoral comprehensive intraoral series, Passport will limit reimbursement to the Allowed Amount for the comprehensive intraoral series, and the fee for the panoramic image will be the responsibility of the Member.
    - Panoramic images are not considered part of a comprehensive intraoral series.
    - Bitewing images are limited to one (1) time each calendar year. Bitewings of any type are not billable to the Member or Passport within six (6) months of a full mouth series unless warranted by special circumstances.
    - Bitewing images of any type are included in the fee of a comprehensive series when taken within six (6) months of the comprehensive images.
    - Image capture procedures are not separately billable services.
- Cone beam image limitations, include:
    - Cone beam capture and interpretation is covered once in a 12-month period.
    - Interpretation of a diagnostic image only is covered for cone beam services.
    - This service is covered no more than once in a 12-month period.
    - Cone beam interpretation is a covered benefit when provided by a different dentist/dental office than the dentist/dental office who provided the cone beam capture only services.
- Pulp vitality tests are allowed once per day when definitive treatment is not performed.
- Specialist consultations are limited to once per lifetime per Provider and count toward the oral exam frequency. Screenings of patients or assessments of patients reported individually when covered, are limited to only one (1) in a 12-month period and included if reported, with any other examination on the same date of service and Provider office.
- Passport will not cover the replacement of amalgam and resin-based composite restorations (fillings) and prefabricated restorations within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations, including reattachment of a tooth fragment, within 24 months are included in the fee for the original restoration.

- Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
- Pulpal debridement and partial pulpotomy for apexogenesis are limited to once per lifetime.
- Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.
- Hemisection (including any root removal), not including root canal therapy, root amputation per root, internal root repair of perforation defects and incomplete endodontic therapy; inoperable, unrestorable or fractured tooth, are limited to once in a lifetime.
- Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
- Pin retention is covered once in any 24-month period.
- Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required images or select Diagnostic procedures.
- Periodontal limitations inlude:
    - Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. In the absence of supporting documentation, no more than two (2) quadrants of scaling and root planing will be covered on the same date of service. See note on additional Covered Services during pregnancy.
    - Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same dentist/dental office.
    - Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous (bone) tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
    - Guided tissue regeneration and/or bone grafts are not covered in conjunction with soft tissue grafts in the same surgical area.
    - Periodontal surgery is subject to a 30-day wait following periodontal scaling and root planing in the same quadrant.
    - Cleanings (regular and periodontal) and full mouth debridement are subject to a 30-day wait following periodontal scaling and root planing if performed by the same Provider office.
    - When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surface, without flap entry and closure, they are covered as a basic benefit and limited to once in a 24-month period.
- Oral Surgery services are covered once in a lifetime except removal of benign odontogenic cysts or tumors, excision of benign lesions and incision and drainage procedures, which are covered once in the same day.
- General anesthesia, intravenous moderate (conscious) sedation is covered only when provided by a dentist in conjunction with covered oral surgery procedures or selected endodontic and periodontal surgical procedures.

- Crowns and inlays/onlays are covered once in any 60-month period except when Passport determines the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- Core buildup, including any pins, is covered once in any 60-month period.
- Post and core services are covered once in any 60-month period.
- Crown and inlay/onlay repairs are covered once in any 60-month period. crowns, inlays/onlays and fixed bridges include repairs for 24 months following installation.
- The benefit for a crown, inlay/onlay or fixed prosthodontic service, when allowed within six (6) months of a restoration, will be reduced by the benefit paid for the restoration.
- Denture repairs are covered once in any six (6) month period except for fixed denture repairs, which are covered once in any 60-month period.
- Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Passport plan will be replaced only after 60 months have passed, except when Passport determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Passport program will be made if Passport determine it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Passport payment for implant removal is limited to one (1) for each implant in 60 months whether provided under Passport or any other dental care plan. Implant/abutment supported removable dentures and fixed dentures will receive a benefit allowance for the corresponding conventional removable appliances. The Member is responsible for the difference in the fee for an implant/abutment supported denture and the fee for a conventional prosthodontic appliance.
- Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments, are covered once in 36 months.
- The fee for accessing and retorquing loose implant screws is included in the fee for the delivery of the implant supported prosthesis, when performed within 6 months of the placement of the prosthesis.
- Debridement of a peri-implant defect or defects surrounding a single implant (with or without osseous contouring), and surface cleaning of the exposed implant surfaces, including flap entry and closure, are covered once in 36 months.
- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be covered.
- Recementation of crowns, inlays/onlays, indirectly fabricated or prefabricated post and core, or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.
- The initial installation of a prosthodontic appliance and/or implants is not covered unless the prosthodontic appliance and/or implant, bridge or denture is made

necessary by natural, permanent teeth extraction occurring during a time the Member was under a Passport plan.

- Occlusal adjustment is allowed once in a 60-month period.
- Passport will limit payment for dentures to a standard partial or complete denture (Member Cost Sharing applies). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six (6) months after placement.
    - Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
    - Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a calendar year and relining is limited to one (1) per arch in a six (6) month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a calendar year and relining is limited to one (1) per arch in a six (6) month period.
    - Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline or rebase service.
    - Recementation of fixed partial dentures is limited to once in a lifetime.
- Frenulectomy is only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician, or if there is a papilla penetrating frenum interfering with closure of a diastema.
- The fees for synchronous/asynchronous Teledentistry services are considered inclusive in overall patient management and are not separately payable services.

Specific dental services are excluded from coverage under this adult routine dental services benefit and are outlined below:

- Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- Cosmetic surgery or procedures for purely cosmetic reasons.
- Maxillofacial prosthetics.
- Provisional and/or temporary restorations.
- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
- Treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing

surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or night guards/occlusal guards and abfraction.

- Any single procedure provided prior to the date the Member became eligible for services under this plan.
- Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- Charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.
- Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- Interim implants.
- Indirectly fabricated resin-based inlays/onlays.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- Treatment by someone other than a Participant Provider or a person who by law may work under a Provider's direct supervision.
- Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, image duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.
- Dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- Procedures having an unsubstantiated prognosis based on a dental consultant's professional review of the submitted documentation.
- Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under the policy, will be the responsibility of the Member and not a covered benefit.
- Deductibles, amounts over plan maximums and/or any service not covered under the dental benefit.
- Services covered under the dental benefit but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- The initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one (1) or more natural, permanent teeth extracted while the Member is covered under the Agreement or was covered under any dental care plan with Passport.The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.
- Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric images, oral/facial photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.

- Services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.
- Endodontic endosseous implants.
- Services or supplies for sealants, fluoride, space maintainers, apexification and transseptal fiberotomy/supra crestal fiberotomy.
- Missed and/or cancelled appointments.
- Actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- The fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- Dental case management motivational interviewing and patient education to improve oral health literacy.
- Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- Extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.
- Cone beam image capture only.
- Diabetes testing.
- Corticotomy (specialized oral surgery procedure associated with orthodontics).
- Antigen or antibody testing.
- Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.
- Services or supplies for sleep apnea.

Skilled Nursing Facility: Passport covers 90 days per Plan year at a Skilled Nursing Facility (SNF) for a Member when the SNF is a Participating Provider and the services are Prior Authorized before they begin. Inpatient Rehabilitative Services are limited to 60 days per calendar year. Covered SNF services include:

- Room and board
- Physician and nursing services
- Medications and injections

Substance Use Disorder (Inpatient and Outpatient): Passport covers Medically Necessary inpatient and outpatient treatment for substance use disorder. Inpatient coverage, in a Participating Provider hospital, is only covered for medical management of withdrawal symptoms. Passport may require authorization for coverage of services, including inpatient and certain outpatient services. Passport covers the following outpatient care for treatment of substance use disorder:

- Short-term residential programs
- Day-treatment programs
- Individual and group substance use disorder counseling
- Individual substance use disorder evaluation and treatment
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms
- Medication-Assisted Treatment (MAT)
- Opioid Treatment Programs (OTPs)

Outpatient care for treatment of substance use disorder does not include therapy or counseling for any of the following: career, marriage, divorce, parental, job, treatment or testing related to autistic spectrum disorder, learning disabilities, and mental disability.

Surgery (Inpatient and Outpatient): Passport covers the inpatient and outpatient surgical services listed below when provided at a Participating Provider facility. Prior Authorization is required.

Inpatient surgical services include:

- Anesthesia
- Antineoplastic drugs
- Discharge planning
- Operating and recovery rooms

Outpatient surgery services provided in any of the following locations:

- Outpatient or ambulatory surgery center
- Hospital operating room
- Clinic
- Physician's office

Please consult the Schedule of Benefits for Outpatient Hospital/Facility Services or Inpatient Hospital Services to determine applicable Member Cost-Sharing.

Temporomandibular Joint Syndrome ("TMJ") Services: Passport covers services to treat temporomandibular joint syndrome if all the following conditions apply:

- The condition is caused by a congenital, developmental or acquired deformity, disease or injury.
- Under the accepted standards of the profession of the health care Provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.
- The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

Transplant Services: Passport covers transplants of organs, tissue, or bone marrow at Participating Provider facilities when Prior Authorized. If a Participating Provider determines that a Member does not satisfy its respective criteria for a transplant, Passport will only cover services the Member received before that determination is made. Passport is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor. In accordance with Passport guidelines for services for living transplant donors, Passport provides certain donation-related services for a donor, or an individual identified as a potential donor, regardless of whether the donor is a Member. These services must be directly related to a covered transplant for the Member. Covered Services may include certain services for evaluation, organ removal, direct follow-up care, harvesting the organ, tissue, or bone marrow and for treatment of complications.

Urgent Care Services: Urgent Care Services are subject to the Cost Sharing in the Schedule of Benefits. Members must get Urgent Care Services from a Participating Provider. Urgent Care Services are those services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury. For after

hours or Urgent Care Services, Members should call their PCP or the Nurse Advice Line. Members who are within the Service Area can ask their PCP what Participating Provider urgent care center to use. It is best to find out the name of a Participating Provider urgent care center ahead of time.

Vision Services (Adult and Pediatric): Passport covers, for all Members, diabetic eye examinations (dilated retinal examinations) once every calendar year. Passport also covers services for medical and surgical treatment of injuries and/or diseases affecting the eye.

Pediatric Vision Services: Passport covers the following vision services for Members under the age of 21:

- Comprehensive vision exam limited to one every calendar year.
- Glasses which are limited to one pair every calendar year, and one replacement if Medically Necessary.
- Contact lenses which are limited to one pair of standard contact lenses every calendar year (or the yearly equivalent) instead of glasses.
- Medically Necessary contact lenses for specified medical conditions.

Low vision optical devices are covered, including low vision services, training, and instruction to maximize remaining usable vision. Follow-up care is covered when services are Medically Necessary and Prior Authorized. Laser corrective surgery is not covered.

Adult Routine Vision Services: Adult routine vision services are available on some plans. Refer to the Schedule of Benefits to see if these services are covered on your Plan. When covered, these benefits include the following vision services for Members age 21 and older when provided by a Participating Provider:

- Comprehensive vision exam limited to one every calendar year
- Routine retinal screening (copay applies)
- Glasses which are limited to one pair every calendar year
- Contact lenses in lieu of glasses

PRESCRIPTION DRUGS

Drugs, Medications and Durable Medical Equipment: Passport covers drugs ordered by Providers, approved by Passport, and filled through pharmacies in Passport's networks. Covered drugs include over-the-counter (OTC) and prescription drugs as listed on the Formulary. Passport also covers medical drugs ordered or given in a participating facility when provided in connection with a Covered Service. Prior Authorization may be required to have certain drugs covered. A Provider who is lawfully permitted to write prescriptions, also known as a Prescriber, may request Prior Authorization on behalf of a Member. Passport will notify the Provider if the request is approved or denied based upon Medical Necessity review.

Pharmacies: Passport covers drugs at retail pharmacies, specialty pharmacies, and mail order pharmacies within our networks. Members may be required to fill a drug with a contracted specialty pharmacy if the drug is subject to Food and Drug Administration (FDA) restrictions on distribution, requires special handling or Provider coordination, or if specialized patient education is required to ensure safe and effective use. To find network pharmacies, please visit PassportHealthPlan.com/Marketplace. A hard copy is also available upon request made to Customer Support.

Passport Formulary: Passport establishes a list of drugs, devices, and supplies that are covered under the Plan's pharmacy benefit. The list of covered products is referred to as the "Formulary." The list shows all the prescription and over-the-counter products Plan Members can get from a pharmacy, along with coverage requirements, limitations, or restrictions on the listed products. The Formulary is available to Members on PassportHealthPlan.com/Marketplace. A hard copy is also available upon request. The list of products on the Formulary are chosen by a group of medical professionals from inside and outside of Passport. This group reviews the Formulary regularly and makes changes every three months based on updates in evidence-based medical practice, medical technology, and new-to-market branded and generic drugs.

Access to Non-Formulary Drugs: The Formulary lets Members and their Prescribers know which products are covered by the Plan's pharmacy benefit. The fact that a drug is listed on the Formulary does not guarantee that a Prescriber will prescribe it for a Member.

Drugs that are not on the Formulary may not be covered by the Plan. These drugs may cost Members more than similar drugs that are on the Formulary if covered on "exception," as described in the next section. Members may ask for non-formulary drugs to be covered. Requests for coverage of non-Formulary drugs will be considered for a medically accepted use when Formulary options cannot be used, and other coverage requirements are met. In general, drugs listed on the Formulary are drugs Providers prescribe for Members to get from a pharmacy and give to themselves. Most injectable drugs that require help from a Provider to use are covered under the medical benefit instead of the pharmacy benefit. Providers have instructions from Passport on how to get advanced approval for drugs they buy and treat Members with. Some injectable drugs can be approved to get from a pharmacy using the Plan pharmacy benefit.

Requesting a Formulary Exception: Passport has a process to allow Members, their representative, or a Prescriber to request clinically appropriate drugs that are not on the

Formulary. They may request coverage for drugs that have step therapy requirements or other restrictions under the Plan benefit that have not been met. Members, their representative, or Prescribers may contact Passport's Pharmacy Department to request a Formulary exception.

If a prescription requires a Prior Authorization review for a Formulary exception, the request can be considered under standard or expedited circumstances.

- Any request that is not considered an expedited exception request is considered a Standard Exception request.
- A request is considered an expedited exception request if it is to treat a Member's health condition that may seriously jeopardize their life, health, or ability to regain maximum function, or when the Member is undergoing a current course of treatment using a non-formulary drug. Trials of pharmaceutical samples from a Prescriber or a drug manufacturer will not be considered as current treatment.

Passport will notify the Member or their representative, and the Prescriber of the coverage determination no later than:

- 24 hours following receipt of an expedited exception request
- 48 hours following receipt of a standard exception request

If the request is denied, Passport will send a letter to the Member or their representative, and the Prescriber. The letter will explain why the drug or product was denied. It is within the Member's rights to purchase the drug at the full cost charged by the pharmacy. If the Member disagrees with the denial of the request, the Member, their representative, or the Prescriber, can appeal Passport's coverage decision. The Prescriber may request to talk to Passport reviewers about the denial reasons.

If an internal appeal of the original coverage determination is requested, Passport will notify the Member, their representative, and the Prescriber, of the internal appeal decision no later than:

- 24 hours following receipt of an appeal on a denied expedited exception request
- 72 hours following receipt of an appeal of a denied standard exception request.

The Member or their representative, or the Prescriber, may also request that an Independent Review Organization (IRO) review Passport's internal appeal decision. Member or their representative, and the Prescriber, will be notified of the IRO decision no later than:

- 24 hours following receipt of an appeal on a denied expedited exception request
- 72 hours following receipt of an appeal of a denied standard exception request.

Requesting a Step Therapy Exception: Passport has a process to allow Members to request a Step Therapy exception for covered drugs that have a Step Therapy requirement. Prescribers may contact Passport's Pharmacy Department to request a Step Therapy exception using the prescription drug prior authorization form and contact information on the PassportHealthPlan.com/Marketplace provider forms page. If the exception is approved, Passport will contact the Prescriber.

Passport will notify the Prescriber of the coverage determination no later than 48 hours following receipt of a step therapy exception request or the exception request will be deemed granted. Passport may request additional information if the request is incomplete or additional clinically relevant information is required. If all information reasonably necessary and requested by Passport is not received timely, this may result in a denial.

If the request is denied, Passport will send a letter to the Member and their Prescriber. The letter will explain why the drug or product was denied. It is within the Member's rights to purchase the drug at the full cost charged by the pharmacy. If the Member disagrees with the denial of the request, the Member can file an internal appeal of Passport's coverage decision. The Prescriber may also request to talk to Passport reviewers about the denial reasons.

Passport will notify the Prescriber of the coverage determination no later than 48 hours following receipt of a step therapy exception internal appeal or the exception will be deemed granted.

If the internal appeal is denied, the Member or Prescriber may request that an Independent Review Organization (IRO) review Passport's decision. The internal appeal denial decision letter will inform the Member or Prescriber of the process to request an external appeal the decision. These instructions are also in the section of this Agreement titled "CLAIMS DECISIONS, GRIEVANCES, INTERNAL AND EXTERNAL APPEALS."

Cost Sharing: Passport puts drugs on different levels called tiers, "Preventive Drugs" through "Specialty Drugs," based on how well they improve health and their value compared to similar treatments. The Schedule of Benefits shows Member Cost Sharing for a one-month supply based on these tiers.

Here are some details about which drugs are on which tiers.

Drug Tier	Description
Preventive Drugs	Nationally recognized preventive service drugs and dosage forms, and family planning drugs and devices (i.e., contraception) with $0 Cost Sharing; additional drugs with $0 Cost Sharing where applicable.
Preferred Generic Drugs	Preferred generic drugs; lowest Cost Sharing.
Preferred Brand Drugs	Preferred brand-name drugs; higher Cost Sharing than preferred generic drugs.
Non-Preferred Drugs	Non-preferred, brand-name and generic drugs; higher Cost Sharing than preferred brand-name and generic drugs used to treat the same conditions.
Specialty Drugs	Specialty drugs (brand-name and generic); Drugs that require special handling, complex counseling or monitoring, limited distribution, or other special pharmacy requirements. Higher Cost Sharing than lower tier drugs used to treat the same

	conditions if available. Depending on state rules, Passport may require Members to use the network specialty pharmacy.
DME	Durable Medical Equipment (“DME”) - Cost Sharing applies; some non-drug products on the Formulary have Cost Sharing determined by the DME Coinsurance.

Cost Sharing on Formulary Exceptions: For drugs or other products that are approved on Formulary exception, the Member will have the “Non-Preferred Drugs” Tier Cost Sharing for non-specialty products or the “Specialty Drugs” Tier Cost Sharing for Specialty products. Please note, for nonformulary brand-name products that have a generic product listed on the Formulary, if coverage is approved on exception, a Member’s share of the cost will also include the difference in cost between the Formulary generic drug and the brand-name drug.

Notice on Third-Party Cost Sharing Assistance: Cost Sharing paid by you or on your behalf for a covered drug will apply as if you paid it and will count toward any applicable Deductible or yearly Out-of-Pocket Maximum under your plan. This includes Third-Party Cost Sharing Assistance. Third-Party Cost Sharing Assistance means discount cards, coupons, cash or other financial help you get from a company, a person, a charitable organization, or a sponsored program for the purpose of paying Cost Sharing on a drug we are covering for you. Amounts you pay or are paid on your behalf for a drug we are not covering or have denied coverage for will not apply.

Site of Care for Provider-administered Drugs Required Program: For Provider-administered drugs that require Prior Authorization, when coverage criteria are met for the medication, a site of care policy is used to determine the medical necessity of the requested site of care. Site of care means the physical location of injection or infusion administration of a drug for a specialized condition. Passport covers injectable and infused medications in an outpatient hospital setting or at a hospital-affiliated infusion suite when the level of care is determined to be medically necessary. To review the site of care policy, please visit PassportHealthPlan.com/Marketplace.

Over-the-Counter Drugs, Products, and Supplements: Passport covers over-the-counter drugs, products, and supplements in accordance with State Law and Federal laws. Only over-the-counter drugs, supplies, and supplements that appear on the Formulary may be covered.

Durable Medical Equipment (DME): Passport will cover DME rental or purchase costs for use with certain drugs when obtained through a contracted vendor. Passport will also cover reasonable repairs, maintenance, delivery, and related supplies for DME. Members may be responsible for necessary DME repair or replacement costs if needed due to misuse or loss of the DME. The Cost Sharing amounts as listed on your Schedule of Benefits apply per purchase or rental period. Prior Authorization may be required for DME to be covered. Coverage may be under the medical benefit or the pharmacy benefit, depending on the type of DME. Please refer to the Formulary for DME and other non-drug products covered under the pharmacy benefit. Please refer to PassportHealthPlan.com/Marketplace or contact Customer Support for more coverage information.

Diabetic Supplies: Passport covers diabetic supplies on the Formulary such as insulin syringes, lancets and lancet puncture devices, blood glucose monitors, continuous glucose monitoring DME, blood glucose test strips, urine test strips, and select pen delivery systems for the administration of insulin. Passport also covers all equipment, supplies, outpatient self-management training and education, including medical nutrition therapy, and all medications necessary for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes if prescribed by a health care provider legally authorized to prescribe the items. Member Cost Sharing for covered insulin medication is limited to $30 per thirty day supply of each prescription insulin drug.

Prescription Drugs to Stop Smoking: Passport covers drugs to help Members stop smoking, with no Cost Share. This includes tobacco cessation medications and over-the-counter nicotine replacement with a prescription. Members should consult their Provider to determine which drug is right for them. Covered drugs are listed on the Formulary. Specifically, Passport will provide coverage for all FDA-approved tobacco cessation services recommended by the United States Preventive Services Task Force, including individual, group, and telephone counseling, and any combination thereof. For services associated with more than two (2) attempts to quit within a twelve (12) month period, or treatment exceeding the duration recommended by the most recently published United States Public Health Service clinical practice guidelines on treating tobacco use, prior authorization may be required.

Day Supply Limit: While Providers determine how much drug, product supply, or supplement to prescribe, Passport may only cover one month of supply at a time for certain products. The Formulary indicates “MAIL” for items that may be covered with a 3-month supply through our network of pharmacies, a contracted mail order pharmacy, or other Plan programs. Quantities that exceed the day supply limits on the Formulary are not covered, with few exceptions.

Prescription Eye Drops: Passport covers prescription eye drop refills as follows:

- If your prescription calls for a 30-day supply, you may obtain a refill between 25-30 days from the later of: (i) the original date you received the prescription or (ii) the date of your most recent refill;
- If your prescription calls for a 90-day supply, you may obtain a refill between 80-90 days from the later of: (i) the original date you received the prescription or (ii) the date of your most recent refill.
- You are also permitted one (1) additional bottle of prescription eye drops if your prescription states than an additional bottle is needed for use in a day care center or school.
- Coverage for an additional bottle shall be limited to one (1) bottle every three (3) months.

Therapeutic Food, formulas, supplements, and low protein modified food products: Passport provides coverage for prescribed treatment of inborn errors of metabolism or genetic conditions, if the food is obtained under the direction of a doctor.

Proration and Synchronization: Passport provides medication proration for a partial supply of a prescription drug if the Member’s pharmacy notifies Passport that the

quantity dispensed is to synchronize the dates that the pharmacy dispenses the prescription drugs, synchronization is in the best interest of the Member, and Member agrees to the synchronization. The proration described will be based on the number of days' supply of the drug dispensed.

Opioid Analgesics for Chronic Pain: Prior Authorization may be required for pharmacy coverage of opioid pain medications to treat chronic pain. Without a Prior Authorization, opioid claims have safety limits, including: short supply per fill and subject to restrictions on long-acting opioid drugs and combined total daily doses. These requirements do not apply to Members in the following circumstances: Opioid analgesics are prescribed to a Member who is a hospice patient, the Member was diagnosed with a terminal condition, or the Member is actively being treated for cancer. Passport will conduct a utilization review for all opioid Prior Authorization requests.

Drugs to Treat Cancer: Passport covers reasonable costs for anti-cancer drugs and their administration. Requests for uses outside of a drug's FDA labeling (i.e., off-label uses) are reviewed for Medical Necessity against standard recommendations for the use of the drug and for the type of cancer being treated. No request is denied solely based on usage outside of FDA labeling. Drugs that Providers treat Members with will be subject to Cost Sharing specified for chemotherapy under the medical benefit for the site where treatment is given. Drugs that Members get from pharmacies will be subject to Cost Sharing specified for the pharmacy benefit. Please refer to the Schedule of Benefits for applicable Cost Sharing. Most new anti-cancer drugs are considered "Specialty Drugs" Tier specialty drugs under the pharmacy benefit. Copayments and deductibles for patient-administered anticancer medications shall not be higher than those for injected or intravenously administered anticancer medications. Certain anti-cancer drugs are covered under a partial fill program. Network pharmacies may dispense newly started anti-cancer drugs half a month's supply at a time for the first several fills until Members are stable on the drug and dose.

Treatment of Human Immunodeficiency Virus (HIV): Passport covers prescription drugs for the treatment of HIV infection, or an illness or medical condition arising from or related to HIV. Drugs must be prescribed within the Provider's scope of practice and approved by the United States Food and Drug Administration (FDA), including Phase III Experimental or Investigational drugs that are FDA approved and are administered according to protocol.

Extended Day Supply Availability of Formulary Drugs: Passport offers Members an option to fill up to 90-day supply at network retail pharmacies or a mail order option for certain drugs in the "Preventive Drugs," "Preferred Generic Drugs," "Preferred Brand Drugs," and "Non-Preferred Drugs" Tiers. Eligible drugs are marked "MAIL" on the Formulary. "Specialty Drugs" Tier specialty drugs are not eligible for 90-day supply programs like Mail Order, though most specialty medications will be shipped to the Member directly. Refer to the PassportHealthPlan.com/Marketplace or contact Member Services for more information.

Off-Label Drugs: Passport will not deny coverage of off-label drug use solely on the basis that the drug will be used outside of the FDA-approved labeling. Passport does cover off-label drug use to treat a covered, chronic, disabling, or life-threatening illness. The drug must be approved by the FDA for at least one indication. The use must be

recognized as standard and effective for treatment of the indication in any of the standard drug reference compendia or substantially accepted peer-reviewed medical literature. Passport may require that other treatments that are also standard have been tried or are not clinically appropriate if permitted under State Law. The off-label drug use request must demonstrate Medical Necessity to treat a covered condition when Prior Authorization is required.

Non-Covered Drugs: Passport does not cover certain drugs, including:

- Drugs not FDA approved or licensed for use in the United States
- Over-the-counter drugs not on the Formulary
- Proposed less-than-effective drugs identified by the Drug Efficacy Study Implementation (DESI) program
- Gene therapy
- Experimental and Investigational drugs
- Weight loss drugs, or diabetic drugs when used off-label to lose weight instead of treating diabetes
- Any drugs that would be illegal to prescribe under federal or State law, regardless of the state in which the drug is prescribed or filled

Passport does not cover drugs to treat conditions that are benefit exclusions, including:

- Cosmetic services
- Hair loss or growth treatment
- Infertility (other than treating an underlying diagnosis which caused infertility)
- Erectile dysfunction
- Sexual dysfunction

EXCLUSIONS

Certain equipment and services are excluded from coverage under this Agreement. These exclusions apply regardless of whether the services are within the scope of a Provider's license, except where expressly stated otherwise in this Section, or where otherwise required by State Law. This is not an exhaustive list of services that are excluded from coverage under this Plan. Please contact Passport Customer Support for questions regarding exclusions. Passport does not cover any services that are not identified and included in the Covered Services section of this Agreement. The Member will be fully responsible for payment for any services that are not covered.

Acupuncture Services: Acupuncture services are not covered.

Artificial Insemination and Conception by Artificial Means: All services related to artificial insemination and conception by artificial means are not covered.

Certain Exams and Services: The following are not covered when performed solely for the purpose of:

- Obtaining or maintaining employment or participation in employee programs
- Obtaining medical coverage, life insurance coverage or licensing, or
- To comply with a court order or when required for parole or probation.

Chiropractic Services: Chiropractic services are not covered, except when provided in connection as manipulative therapy outlined in the Habilitation and Rehabilitation Services section of this agreement. Manipulation Therapy includes both osteopathic and chiropractic manipulation therapy used for treating problems associated with bones, joints and the back. Chiropractic therapy focuses on the joints of the spine and the nervous system. Osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.

Cosmetic Services: Services that are intended primarily to change or maintain a Member's physical appearance are not covered. This exclusion does not apply to any services specifically covered in any section of this Agreement.

Court Ordered Non-Medically Necessary Care: Services that are court ordered but not Medically Necessary, unless required by State Law.

Custodial Care: Assistance with activities of daily living are not covered. This exclusion does not apply to assistance with activities of daily living provided as part of covered hospice, skilled nursing facility, or inpatient Hospital care.

Digital Health and Digital Therapeutics: Mobile applications, software, or hardware devices marketed as digital therapeutics to prevent, manage, or treat medical disorders or behavioral conditions are not covered. This does not apply to formulary continuous glucose monitors or covered insulin pump devices, which are considered durable medical equipment, and are subject to Prior Authorization.

Disposable Supplies: Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace- type bandages, diapers, underpads, and other incontinence supplies are not covered.

Erectile Dysfunction: Passport does not cover drugs or treatment for erectile dysfunction.

Experimental or Investigational Services: Passport does not cover Experimental or Investigational services; however, this exclusion does not apply to Services covered under Approved Clinical Trials section.

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy (including stem cell therapy), and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Coverage for other health care services relating to a condition, for which these types of treatments are available, is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization.

Hair Loss or Growth Treatment: Items and services for the promotion, prevention, or other cosmetic treatment of hair loss or hair growth are not covered.

Homeopathic and Holistic Services: Acupuncture and other non-traditional services including, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy are not covered.

Incarceration: Passport will not cover services for Members when rendered while the Member is incarcerated unless a court order specifically requires coverage.

Infertility Services: Passport does not cover infertility services and supplies except as required by State Law. Passport does not cover insemination and conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Intermediate Care: Care in a licensed intermediate care facility is not covered. This exclusion does not apply to services covered under in the Covered Services section.

Non-Healthcare Items and Services: Passport does not cover services that are not healthcare services, for example:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services that increase academic knowledge or skills, teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching Members how to read if they have dyslexia
- Educational testing

- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional-growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy
- Examinations related to job, athletic (sports physicals), or recreational performance

Male Condoms: Male condoms are not covered except those on formulary for women's health preventative services.

Massage Therapy: Massage therapy is not covered.

Medical Tourism: Passport will not cover any expenses related to medical tourism. Medical tourism refers to traveling outside of the United States to receive medical care. This includes, but is not limited to, elective procedures, surgeries, treatments, and any follow-up care related to services received outside the country. Members who choose to seek medical care outside the United States will be fully responsible for all costs incurred.

Non-Emergent Services Obtained in an Emergency Room: Services provided within an Emergency room by a Participating or Non-Participating Provider, which do not meet the definition of Emergency Services, are not covered.

Oral Nutrition: Outpatient oral nutrition is not covered, such as dietary or nutritional supplements, supplements, herbal supplements, weight loss aids, and food.

Primary Payor Services: Any services where other coverage is primary to Passport must be first paid by the primary payor before coverage under this Agreement can be considered. Please refer to the Coordination of Benefits section for additional information.

Private Duty Nursing: Nursing services provided in a facility, usually to one patient, are not covered. Private duty nursing services are generally provided by independently contracted nurses, rather than through an agency, such as a home healthcare agency. There is a limit of 250, 8-hour visits per calendar year for such private duty nursing services. See the Home Healthcare benefit for details of coverage.

Provider-to-Provider Consultation: Passport does not cover interprofessional consultations between providers without the member present.

Provider Incurred Costs: Passport will not cover any expenses, fees, taxes, or surcharges imposed on the Member by any Provider or Facility, that are the Provider or Facility's responsibility to pay.

Reconstructive Surgery: The following reconstructive surgery services are not covered:

- Surgery that, in the judgment of a Participating Provider physician specializing in reconstructive surgery, offers only a minimal improvement in appearance
- Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance

Residential Care: Care in a facility where a Member's stay overnight is not covered; however, this exclusion does not apply when the overnight stay is part of covered care in any of the following:

- A Hospital,
- A skilled nursing facility,
- Inpatient respite care covered in the Hospice Care section,
- A licensed facility providing crisis residential services covered under Mental Health Services (inpatient and Outpatient) section, or
- A licensed facility providing transitional residential recovery services covered under the Substance Use Disorder (Inpatient and Outpatient) section.

Routine Foot Care Items and Services: Routine foot care items and services are not covered, except for Members with diabetes.

Services Not Approved by the FDA: Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require FDA approval in order to be sold in the U.S. but are not approved by the FDA are not covered. This exclusion applies to services provided anywhere, even outside the U.S. This exclusion does not apply to services covered under Approved Clinical Trials section. Please refer to the Appeals and Grievances section for information about denied requests for Experimental or Investigational services.

Services Provided Outside the United States: Except as otherwise provided in this Agreement, any services (both emergency and non-emergency), supplies, or prescription drugs received outside the United States are not covered. When death occurs outside the United States, the medical evacuation and repatriation of remains is not covered.

Services Performed by Unlicensed People: Services performed by people who are not required by State Law to possess valid licenses or certificates to provide healthcare services are not covered, except otherwise covered by this Agreement.

Services Related to a Non-Covered Service: When a service is not covered, all services related to the non-Covered Service are not covered. This exclusion does not apply to services Passport would otherwise cover to treat complications of the non-Covered Service. Passport covers all Medically Necessary basic health services for complications for a non-Covered Service. If a Member later suffers a life-threatening complication such as a serious infection, this exclusion will not apply. Passport would cover any services that Passport would otherwise cover to treat that complication.

Services Rendered by Immediate Family: Any service rendered by an immediate family member of the Member's family.

Services with No Member Incurred Cost: Any service, supplies, or equipment that would be provided without cost to the Member in the absence of Passport covering the charge.

Sexual Dysfunction: Treatment of sexual dysfunction, regardless of cause, including devices, implants, surgical procedures, and medications.

Surrogacy: Services for anyone in connection with a surrogacy arrangement are not covered, except for otherwise Covered Services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Trigger Point Injections: Trigger point injections are not covered, except when used for the treatment of temporomandibular joint (TMJ) disorders.

Travel and Lodging Expenses: Travel and lodging expenses are not covered. Passport may pay certain expenses that Passport preauthorizes in accordance with Passport's travel and lodging guidelines. Passport's travel and lodging guidelines are available from Customer Support.

CLAIMS

Filing a Claim: Members or Providers must promptly submit to Passport claims for Covered Services rendered to Members. All claims must be submitted in a form approved by Passport and must include all medical records pertaining to the claim if requested by Passport or otherwise required by Passport's policies and procedures. Claims must be submitted by the Member or Provider to Passport within 365 calendar days after the following have occurred:

- Discharge for inpatient services or the date of service for outpatient services; and
- Provider has been furnished with the correct name and address for Passport.

If Passport is not the primary payer under coordination of benefits or third-party liability, the Provider must submit claims to Passport within 30 calendar days after final determination by the primary payer. Except as otherwise provided by State Law, any claims that are not submitted to Passport within these timelines are not eligible for payment and Provider waives any right to payment

Claim Processing: Claims payment will be made to Participating Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Passport have agreed in writing to an alternate payment schedule, Passport will pay the Provider of service within 30 calendar days after receipt of a claim submitted with all relevant medical documentation and that complies with Passport billing guidelines and requirements, or notify the provider electronically or in writing of Passport's intent to contest the claim. The receipt date of a claim is the date Passport receives either written or electronic notice of the claim.

Clean claims involving organ transplants will be paid, denied, or contested within sixty (60) calendar days from the date that Passport or its processing entity receives the claim.

If Passport contests part of a claim, Passport will pay within these time frames the non-contested part of the claim and notify the provider, electronically or in writing, of Passport's reasons for not paying the claim. If Passport denies the claim entirely, Passport will provide its reasons for denial.

Member Reimbursement: With the exception of any required Cost Sharing amounts, if a Member has paid for a Covered Service or prescription that was pre-approved or does not require pre-approval, Passport will repay the Member. The Member must submit the claim for reimbursement within 12 months from the date they made the payment.

For covered medical services, Members must mail this information to Passport Customer Support at the address on the inside cover of this Agreement. The Member will need to mail Passport a copy of the bill for the Covered Services from the Provider or facility and a copy of the receipt. The Member should also include the name of the Member for whom they are submitting the claim and their policy number.

For covered prescription drugs, Members must complete a Reimbursement Form found in the Forms section of PassportHealthPlan.com/Marketplace. Members must include a copy of the prescription label and pharmacy receipt when submitting the request form to

the address as instructed on the form. After the Member's request for reimbursement is received, it will be processed as a claim under their coverage. The Member will receive a response within 30 calendar days. If the claim is accepted, a reimbursement check will be mailed to the Member. If the claim is denied, the Member will receive a letter explaining why the claim was denied. If the Member does not agree with the denial, the Member may file an appeal as described in this Agreement.

Paying Bills: Members should refer to their Schedule of Benefits for their Cost Sharing responsibilities for Covered Services. Members may be liable to pay full price for services when:

- The Member asks for and gets medical services that are not Covered Services.
- Except in the case of Emergency Services, the Member asks for and gets healthcare services from a Provider or facility that is a Non-Participating Provider without getting a prior approval from Passport.

If Passport fails to pay a Participating Provider for providing Covered Services, the Member will not be responsible for paying the Participating Provider for any amounts owed by Passport. This does not apply to Non-Participating Providers.

LEGAL NOTICES

Third Party Liability and Subrogation: If a Member suffers an illness, injury, or condition for which any third party is alleged to be liable or responsible, you must promptly notify Passport in writing.

If Passport pays a claim for a Member, Passport has immediate subrogation rights and the right to recover from any liable or responsible third party any benefits paid related to the Member's injury, illness, or condition. Member assigns to Passport the right to take legal action against any responsible third party. Member agrees to provide Passport with any relevant information upon request and to participate in any phase of legal action, such as discovery, depositions, and trial testimony.

If a Member does not cooperate with Passport, or if a Member does anything that interferes with Passport's rights, Passport may take legal action against the Member. Members also agree not to assign the right to take legal action to someone else without Passport's written consent.

If the illness, injury, or condition that led to subrogation involves a minor child, then the child's guardian or parents are responsible for cooperating with the subrogation and reimbursement process. If the illness, injury, or condition ends in the wrongful death of a Member or dependent, then the obligation to cooperate passes to the Member or dependent's personal representative.

Passport's Right of Reimbursement: Passport has the right to be reimbursed if a liable or responsible third party pays the Member directly. If a Member receives any services under the Plan for an illness, injury, or condition alleged to be caused by or caused by a third party and subsequently receive any amount as a judgment, settlement, or other payment from any third party, Passport is entitled to a first-priority right of reimbursement of the amounts paid or to be paid on your behalf for the services related to the illness, injury, or condition for which any third party is alleged to be liable or responsible.

Passport's Rights Take Priority: Passport's rights of subrogation and reimbursement have priority over other claims and will not be affected by any equitable doctrine. The proceeds of any judgment or settlement obtained by a Member or Passport from any liable or responsible third party on account of injury, illness, or condition shall first be applied to satisfy Passport's subrogation and reimbursement rights. Passport is entitled to recover the amounts paid even if you are not or have not been compensated by the liable or responsible third party for all costs related to your illness, injury, or condition.

Passport is not obligated to pursue reimbursement or take legal action against a third party, either for Passport's own benefit or on your behalf. Passport's rights will not be affected if Passport does not participate in any legal action you take related to your injury, illness, or condition.

Worker's Compensation: Passport will not furnish benefits under this Agreement that duplicate the benefits to which the Member are entitled under any applicable workers' compensation law. The Member is responsible for all action necessary to obtain payment under workers' compensation laws where payment under the workers

compensation system can be reasonably expected. Failure to take proper and timely action will preclude Passport's responsibility to furnish benefits to the extent that payment could have been reasonably expected under Workers' Compensation laws. If a dispute arises between the Member and the Workers' Compensation carrier as to a Member's ability to collect under workers' compensation laws, Passport will provide the benefits described in this Agreement until resolution of the dispute. If Passport provides benefits which duplicate the benefits the Member is entitled to under workers' compensation law, Passport will be entitled to reimbursement for the reasonable cost of such benefits.

Changes in Premiums and Cost Sharing: Your premium rate is guaranteed for the duration of your plan year, which in certain circumstances may be less than 12 months. We reserve the right to change the Premium annually. Any change to this Agreement is effective after 60 days' notice to the Subscriber's address of record with Passport.

Acts Beyond Passport's Control: If circumstances beyond the reasonable control of Passport, including any major disaster, epidemic, complete or partial destruction of facility, war, riot, or civil insurrection, result in the unavailability of any facilities, personnel, or Participating Providers, then Passport and the Participating Provider shall provide or attempt to provide Covered Services in so far as practical, according to their best judgment, within the limitation of such facilities and personnel and Participating Providers. Neither Passport nor any Participating Provider shall have any liability or obligation for delay or failure to provide Covered Services if such delay or failure is the result of any of the circumstances described above.

Waiver: Passport's failure to enforce any provision of this Agreement shall not be construed as a waiver of that provision or any other provision of this Agreement or impair Passport's right to require a Member's performance of any provision of this Agreement.

Non-Discrimination: Passport does not discriminate in hiring staff or providing medical care on the basis of pre-existing health condition, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex or genetic information.

Genetic Information: Passport will not collect genetic information from the Member for purpose of underwriting or otherwise. Passport will not request or require the Member to take any genetic tests. Passport will not adjust premiums or otherwise limit coverage based on genetic information.

Agreement Binding on Members: By electing coverage or accepting benefits under this Agreement, all Members legally capable of contracting, and the legal representatives for all Members incapable of contracting, agree to all provisions of this Agreement.

Assignment: A Member may not assign this Agreement or any of the rights, interests, claims for money due, benefits, claims, or obligations hereunder without Passport's prior written consent. Consent may be refused at Passport's discretion.

Governing Law: Except as preempted by Federal Law, this Agreement will be governed in accordance with State Law and any provision that is required to be in this

Agreement by State or Federal Law shall bind Passport and Members whether or not set forth in this Agreement.

Invalidity: If any provision of this Agreement is held illegal, invalid or unenforceable in a judicial proceeding, such provision shall be severed and shall be inoperative, and the remainder of this Agreement shall remain operative and in full force and effect.

Notices: Any notices required by Passport under this Agreement will be sent to the most recent address or record for the Subscriber. The Subscriber is responsible for reporting any change in address to the Marketplace.

Legal Action: No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Time Limit on Certain Defenses: After 3 years from the date of issue of this Agreement, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Agreement shall be used to void the Agreement or to deny a claim for loss incurred or disability (as defined in the Agreement) commencing after the expiration of such 3-year period. No claim for loss incurred or disability (as defined in the Agreement) commencing after 3 years from the date of issue of this Agreement shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Agreement.

Proofs of Loss: Written proof of loss must be furnished to Passport at its said office in case of claim for loss for which this Agreement provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which Passport is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

Proof of Loss Claim Form: Passport, upon receipt of a notice of claim, will provide such forms as are usually provided by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the Member shall be deemed to have complied with the requirements of this Agreement as to proof of loss upon submitting, within the time fixed in the Agreement for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Notice of Claim: Written notice of claim must be given to the insurer within sixty (60) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at 5100 Commerce Crossings Drive Louisville, KY 40229

or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Proof of Loss Time of Payment of Claims: Indemnities payable under this Agreement for any loss other than loss for which this Agreement provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Agreement provides periodic payment will be monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting payment which may be prescribed herein and effective at the time of payment. If no designation or provision is then effective, any indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to a beneficiary or to the estate. All other indemnities will be payable to the insured.

Physical Examinations: Passport, at its own expense, shall have the right and opportunity to examine the person of the Member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by State and Federal Law.

Automobile Accident-Related Injuries: Passport does not exclude coverage for automobile accident-related injuries, except as permitted by State Law.

Illegal Occupation or Criminal Activity: Passport is not liable for any loss to which a contributing cause was the Member's commission of or attempt to commit a felony or to which a contributing cause was the Member’s being engaged in an illegal occupation or other willful criminal activity.

Wellness and Other Program Benefits: This Agreement includes access to a wellness program offered to encourage Members to complete health activities that support their overall health. The program is voluntary and available to all Subscribers at no cost. The program is additionally available to Dependents 18 years and older at no cost. Passport may offer you rewards or other benefits for participating in certain health activities and programs provided by Participating Providers. The rewards and program benefits available to you may include premium credits or other benefits such as gift cards.

Members should consult with their PCP before participation. The wellness program is optional, and the benefits are made available at no additional cost to eligible Members. Rewards and program benefits are available for redemption only while the Subscriber or eligible Dependent is currently enrolled with a Passport marketplace health plan. For more information, please contact Customer Support.

Change of Beneficiary: Unless the Member makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Member and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of benefits or Claims under this Agreement or to any change of beneficiary

or beneficiaries, or to any other changes in this Agreement. However, unless Passport has reliable, written documentation of a Member's lawful designated beneficiary, Passport reserves the right to pay claims for money due, benefits or claims owing under this Agreement only to the Subscriber or applicable Member (as determined by Passport) and to refuse to honor any assignment of monies, benefits or Claims under this Agreement.

Annual Health Activity: Passport encourages Members to complete an Annual Wellness Exam (a comprehensive physical exam), at no cost, through their PCP or an in-home health assessment exam facilitated through Passport.

No Surprises Act:

Notice of Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in the Passport network of participating providers (or in-network).

"Out-of-network" describes providers and facilities that haven't signed a contract with Passport Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services:
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments or coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center:

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility within Passport's network.

When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Passport will pay out-of-network providers and facilities directly for covered services.

Passport must generally:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- For the services addressed in this Notice, base what you owe the provider or facility (your plan cost-sharing) on what Passport would pay an in-network provider or facility for the service and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or covered out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact: 1-800-985-3059. Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

CLAIMS DECISIONS, GRIEVANCES, INTERNAL AND EXTERNAL APPEALS

Grievance: A written complaint submitted by or on behalf of a Member. A complaint is any dissatisfaction that a Member has with Passport or any Participating Provider that is not related to the denial of healthcare services. For example, a Member may be dissatisfied with the hours of availability of a Participating Provider. Issues relating to the denial of health care services are Appeals and should be filed with Passport or the Kentucky Department of Insurance in the manner described in the Internal Appeals section below. Passport recognizes the fact that a Member may not always be satisfied with the care and services provided by our Participating Providers. Passport wants to know about concerns and any complaints Members may have. Passport will respond to a Member complaint no later than 30 days from the date Passport received it. A Member may contact Passport for assistance with filing a complaint over the phone, by mail or fax using the following contact information.

Passport Appeals and Grievances Department Address:

Passport by Molina Healthcare
Attention: Appeals & Grievances
PO Box 182273
Chattanooga, TN 37422

Phone: (833) 644-1621, Monday – Friday 8am – 6pm Eastern time
TTY/TDD: 711

Website: PassportHealthPlan.com/Marketplace

Member may also contact the Kentucky Department of Insurance Division of Consumer Protection:

Kentucky Department of Insurance
Division of Consumer Protection
P.O. Box 517
Frankfort, KY 40602

Phone: 800-595-6053 (Kentucky residents only) or 502-564-6034
(ask to speak to a Consumer Complaint Investigator)

Website: http://insurance.ky.gov/Home.aspx?Div_ID=4

Definitions: For the purposes of this section, the following definitions apply:

Coverage Denial: A determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person’s health benefit plan.

Final Adverse Benefit Determination: An Adverse Benefit Determination that is upheld after the internal appeal process. If the period allowed for the internal appeal elapses without a determination by Passport, then the internal appeal will be deemed a Final Adverse Benefit Determination.

Appointing a Representative: If a Member would like someone to act on their behalf regarding a claim or an appeal of an Adverse Benefit Determination, the Member may appoint an authorized representative. Members should send the representative's name, address, and telephone contact information to the Passport Appeals and Grievances Department Address, listed in the Complaints section. Members must pay the cost of anyone the Member hires to represent or help the Member.

Initial Denial Notices: Written notice of an Adverse Benefit Determination (including a partial claim denial) will be provided to Member within the time frames noted within this section. With respect to Adverse Benefit Determinations involving an Urgent Care Service, notice may be provided to Member orally within the timeframes noted within this section. If oral notice is given, written notification must be provided no later than 3 days after oral notification.

An Adverse Benefit Determination notice will identify the claim involved, convey the specific reason for the Adverse Benefit Determination (including the denial code and its meaning), the specific provisions upon which Passport based the determination, and the contact information for Passport and the Kentucky Department of Insurance, which is available to assist Member with the internal and external appeal processes. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary.

The notice will disclose if any internal policy, protocol, or similar criterion was relied upon to deny the claim. A copy of the policy, protocol, or similar criterion will be provided to Member, free of charge. In addition to the information provided in the notice, Members have the right to request the diagnosis, treatment codes and descriptions upon which the determination is based. The notice will describe Passport's review procedures and the time limits applicable to such procedures following an Adverse Benefit Determination on review.

If an Adverse Benefit Determination is based on Medical Necessity, Experimental or Investigational treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the product to Member medical circumstances. In the case of an Adverse Benefit Determination involving a claim for Urgent Care Service, the notice will provide a description of Passport's expedited review procedures, which are described below.

Internal Appeals: Members must appeal an Adverse Benefit Determination within 180 days after receiving written notice of the denial (or partial denial). Members may appeal an Adverse Benefit Determination by means of written notice to Passport, in person, orally, or by mail, postage prepaid. Adverse Benefit Determinations for electronic Prior Authorizations are included. Member Appeals should include:

- The date of the Member Appeal
- Member name (please print or type)
- The date of the service Passport denied
- Member identification number, claim number, and Provider name as shown on the explanation of benefits

Members should keep a copy of the Appeal for their records. Members may request an expedited internal appeal of an Adverse Benefit Determination involving any urgent service orally or in writing. In such case, all necessary information will be transmitted between Passport and the Member by telephone, fax, or other available similarly expeditious method, to the extent permitted by applicable law. Members may also request an expedited external review of an Adverse Benefit Determination involving any urgent service at the same time a request is made for an expedited internal appeal of an Adverse Benefit Determination if the Member's Provider certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the Member's life or health, or would jeopardize the Member's ability to regain maximum function if treated after the time frame of an expedited internal appeal. Members may not file a request for expedited external review unless Members also file an expedited internal appeal. Determination of appeals of Adverse Benefit Determinations will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial Adverse Benefit Determination or a subordinate of that person. The determination will consider all comments, documents, records, and other information submitted by the Member relating to the claim.

On appeal, Member may review relevant documents, request copies of any relevant information (which will be provided free of charge) and may submit issues and comments in writing. Upon request, Members may also discover the identity of medical or vocational experts whose advice was obtained on behalf of Passport in connection with the Adverse Benefit Determination being appealed, as permitted under applicable law.

If Passport bases the Adverse Benefit Determination in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is Experimental or Investigational, or not Medically Necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

If new or additional evidence is relied upon or if new or additional rationale is used during the internal appeal process, Passport will provide to Members, free of charge, the evidence or rationale as soon as possible and in advance of the appeals decision in order to provide Member a reasonable opportunity to respond. However, if Passport receives the new or additional evidence so late that it would be impossible to provide it to Member in time for Member to have a reasonable opportunity to respond, the period for providing notice of Passport's appeal decision will be tolled until the Member has a reasonable opportunity to respond. After a Member responds or has a reasonable opportunity to respond but fails to do so, Passport will notify the Member of Passport's decision as soon as reasonably possible, considering the medical circumstances. Member coverage will remain in effect pending the outcome of Member internal appeal.

Timeframes for Decisions on Appeal: For appeals of Adverse Benefit Determinations, Passport will make decisions and provide notice of the decisions as follows:

Timeframe for Appeal Response	
Request Type	**Timeframe for Decision**
Urgent Care Service Decisions	Within 24 hours from receipt of request, but no greater than 72 hours if additional information is required. (If all information reasonably necessary and requested by Passport is not received in this timeframe this may result in a denial. Passport will inform the Member of the reason for denial.)
Pre-Service and Post-Service Decisions	Within 30 days from receipt of request. (If all information reasonably necessary and requested by Passport is not received in this timeframe this may result in a denial. Passport will inform the Member of the reason for denial.)

An Urgent Care appeal or claims involving Urgent Care Services are processed as timely as possible given the circumstances and will always be processed within no more than 24 hours from receipt of requestor, but no greater than 72 hours if additional information is required. If all information reasonably necessary and requested by Passport is not received in this timeframe this may result in a denial. Passport will inform Member of the reason for denial.

Appeals Denial Notices: Notice of a Final Adverse Benefit Determination (including a partial denial) will be provided to the Member by mail, postage prepaid, by fax or by e-mail, as appropriate and as required by State Law, within the time periods noted above. A notice that Passport have denied a claim appeal will include:

- Enough information to identify the claim involved;
- State of licensure, medical license number, and the title of the person making the decision,
- The specific reason or reasons for the Final Adverse Benefit Determination, including the denial code and its meaning;
- Reference to the specific product provision upon which the determination is based;
- A statement that Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Member claim for benefits;
- If Passport relied upon any internal Passport policy, protocol or similar criterion to deny the claim, then a copy of the policy, protocol or similar criterion will be provided to Member, free of charge, along with a discussion of the decision;
- A statement of Member right to external review or review by the Kentucky Department of Insurance, a description of the external review process, and the forms for submitting an external review request, including release forms authorizing Passport to disclose protected health information pertinent to the external review; and

- If Passport bases a Final Adverse Benefit Determination on Medical Necessity, Experimental or Investigational treatment or similar exclusion or limitation, the notice will provide:
    - An explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of this Agreement to Member medical circumstances.
    - A notice of voluntary alternative dispute resolution options, as applicable.

For assistance with appeals, complaints or the external review process, a Member may write or call the Kentucky Department of Insurance Office of Consumer Affairs via the contact methods identified in this section. In addition to the information provided in the notice, Members have the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

External Review: After Members receive a Final Adverse Benefit Determination or if Members are otherwise permitted, as described above, Members may request an external review if a Member believes that a healthcare service has been improperly denied, modified, or delayed on the grounds that the healthcare service doesn't meet Passport's requirements for Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness of a covered benefit, or is Experimental or Investigational.

An external review may be conducted by an Independent Review Organization (IRO) if the following criteria are met:

1. Passport, its designee, or agent has rendered a Final Adverse Benefit Determination to the Member;
2. Member has completed Passport's internal appeal process, or Passport failed to timely make a determination or notification;
3. Member was enrolled in Passport's health plan on the date of service or, if this is a prospective denial, Member was enrolled and eligible to receive covered benefits under the Passport health plan on the date the proposed service was requested; and
4. The entire course of treatment or service would cost you at least one hundred dollars ($100) if you had no insurance.

You must submit a request for external review to Passport within four months of receiving a Final Adverse Benefit Determination. With this request you must provide Passport written consent authorizing the IRO to obtain all necessary medical records from both Passport and any provider utilized for in the Final Adverse Benefit Determination.

There are three types of IRO reviews: 1) standard external review, 2) expedited external review, and 3) external review of Experimental or Investigational treatment.

Standard External Review: A standard external review is normally completed within 21 days. An extension of up to 14 calendar days may be allowed if you and Passport agree.

Expedited External Review: An expedited review for urgent medical situations, including reviews of Experimental or Investigational treatment involving an urgent medical situation are normally completed within 24 hours and can be requested if any of the following applies:

Member is hospitalized or, in the opinion of your physician, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

1. Placing the Member's health, or that of an unborn child (in the case of pregnancy) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of a bodily organ or part.

External Review of Experimental and Investigational Treatment: Requests for standard or expedited external reviews that involve Adverse Benefit Determinations or Final Adverse Benefit Determinations for treatments that are Experimental or Investigational may proceed if the Member's Provider certifies one of the following:

- Standard health care services have not been effective in improving Member condition,
- Standard health care services are not medically appropriate for Member, or
- No available standard health care service covered by Passport is more beneficial than the requested health care service

Request for External Review in General: Members must request an external review within four months of the date of the notice of Adverse Benefit Determination or Final Adverse Benefit Determination issued by Passport. All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally. If the request is complete, Passport will initiate the external review and notify Members in writing that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Kentucky Department of Insurance (as applicable) for the purpose of submitting additional information. The notice will also inform Members that, within 10 business days after receipt of the notice, Members may submit additional information in writing to the IRO in the review.

Passport will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRO or the Kentucky Department of Insurance (as applicable). All records provided to IROs are handled as confidential records. If the request is not complete Passport will inform Members in writing and specify what information is needed to make the request complete. If Passport determines that the Adverse Benefit Determination is not eligible for external review, Passport will notify Members in writing, provide Members with the reason for the denial, and inform Members that the denial may be appealed to the Kentucky Department of Insurance. The Kentucky Department of Insurance may determine the request is eligible for external review regardless of the decision by Passport and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of this Agreement and State Law. Passport will pay the costs of the external review. Members will be assessed a filing fee of $25 to be paid to IRO. This fee may be waived if the IRO determines that the fee creates a financial hardship on Members. The fee shall be refunded if the IRO finds in favor of Members. If Members submit multiple

requests for External Reviews within a one-year period, they will not have to pay more than $75 per year in filing fees.

IRO Assignment: The Kentucky Department of Insurance randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of health care service. Passport and the IRO are automatically notified of the assignment.

IRO Review and Decision: The IRO must forward, upon receipt, any additional information it receives from Members to Passport. At any time, Passport may reconsider its Adverse Benefit Determination and provide coverage for the healthcare service. Reconsideration will not delay or terminate the external review. If Passport reverses the Adverse Benefit Determination, Passport will notify Members, the assigned IRO and the Kentucky Department of Insurance within 1 day of the decision. Upon receipt of the notice of reversal by Passport, the IRO will terminate the review.

In addition to all documents and information considered by Passport in making the Adverse Benefit Determination, the IRO must consider things such as Members' medical records, the attending healthcare professional's recommendation, consulting reports from appropriate healthcare professionals, the terms of this Agreement, and the most appropriate practice guidelines.

The IRO will provide a written notice of its decision within 21 days for a standard review or within 24 hours for an expedited review. This notice will be sent to Members, Passport, and the Kentucky Department of Insurance and must include the following information:

1. The findings for either Passport or Member regarding each issue under review;
2. The proposed service, treatment, drug, device, or supply for which the review was performed;
3. The relevant provisions in Passport's plan and how they applied;
4. The relevant provisions of any nationally-recognized and peer-reviewed medical or scientific documents used in the external review;
5. The title, professional license number, state of licensure, and specialty or subspecialty certifications, if any, of the reviewer;
6. The date the decision was rendered; and
7. A statement that (a) the decision is final and binding on Passport, and (b) if the Member is dissatisfied with the decision, a comment, question, or complaint may be submitted in writing to the Kentucky Department of Insurance.

Binding Nature of External Review Decision: An external review decision is binding on Passport except to the extent Passport has other remedies available under State Law. The decision is also binding on Members except to the extent that Members have other remedies available under applicable State Law or federal law. Members may not file a subsequent request for an external review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to Passport. If Members have questions about Members' rights or need assistance, Members may contact the Kentucky Department of Insurance Division of Consumer Protection.

NONDISCRIMINATION NOTICE

Passport by Molina Healthcare meets Federal civil rights laws that relate to health care services. Passport offers services to all members regardless of race, color, national origin, age, disability, or sex. Passport does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. This includes gender identity, pregnancy, sex and stereotyping.

To help you talk with us, we offer these services free of charge:

- Aids and services for people with disabilities
- Skilled sign language interpreters
- Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills. This includes:
    - Skilled interpreters
    - Material translated in your language
    - Materials that are easy-to-read

If you need these services, call Member Services at (833) 644-1621. Hearing Impaired: Kentucky Relay (800) 648-6057 or 711.

If you think that Passport has not provided these services or treated you differently based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY, 711. Mail your complaint to:

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also email your complaint to civil.rights@molinahealthcare.com. Or, fax your complaint to (502) 585-8461.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. To get a copy of the form, visit http://www.hhs.gov/ocr/office/file/index.html. You can mail it to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

You can also send it through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you need help, call (800) 368-1019. TTY users may call (800) 537-7697.

You can get this Agreement and other plan information in large print for free. To get materials in large print, call Member Services at (833) 644-1621.

If English is not your first language (or if you are reading this on behalf of someone who doesn’t read English), we can help. Call Member Services at (833) 644-1621. You can ask us for the information in this handbook in your language. We have access to interpreter services and can help answer your questions in your language.

Non-Discrimination Notice – Section 1557
Molina Healthcare - Marketplace

Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of age, color, disability, national origin (including limited English proficiency), race, or sex (consistent with the scope of sex discrimination described at § 92.101(a)).

To help you effectively communicate with us, Molina Healthcare provides services free of charge and in a timely manner:

- Molina Healthcare provides reasonable modifications and appropriate aids and services to people with disabilities. This includes: (1) Qualified interpreters. (2) Information in other formats, such as large print, audio, accessible electronic formats, Braille.

- Molina Healthcare provides language services to people who speak another language or have limited English skills. This includes: (1) Qualified oral interpreters. (2) Information translated in your language.

If you need these services, contact Molina Member Services at 1-833-644-1621 or TTY/TDD: 711, Monday to Friday, 8 a.m. to 6 p.m., local time.

If you believe we have discriminated on the basis of age, color, disability, national origin, race, or sex, you can file a grievance. You can file a grievance by phone, mail, email, or online. If you need help writing your grievance, we will help you. You may obtain our grievance procedure by visiting our website at https://www.molinahealthcare.com/members/common/en-US/Notice-of-Nondiscrimination.aspx

Call our Civil Rights Coordinator at 1-866-606-3889, TTY/TDD: 711 or submit your grievance to:

Civil Rights Unit
200 Oceangate
Long Beach, CA 90802
Email: civil.rights@molinahealthcare.com
Website: https://molinahealthcare.Alertline.com

You can also file a civil rights complaint (grievance) with the U.S. Department of Health and Human Services, Office for Civil Rights, online through the Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019
TTY/TDD: 800-537-7697

Complaint forms are available here: https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf

English	For free language assistance services, and auxiliary aids and services, call 1-833-644-1621 (TTY: 711).
Spanish Español	Para obtener servicios gratuitos de asistencia lingüística, así como ayudas y servicios auxiliares, llame al 1-833-644-1621 (TTY: 711).
Chinese 中文（简体）	如需免费的语言协助服务以及辅助工具和服务，请致电1-833-644-1621（TTY用户请拨打 711）。
German Deutsch	Kostenlose Sprachassistenzdienste, Hilfsmittel und Dienstleistungen erhalten Sie unter 1-833-644-1621 (TTY: 711).
Vietnamese Tiếng Việt	Để sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí cũng như các dịch vụ và tính năng hỗ trợ thêm, hãy gọi 1-833-644-1621 (TTY: 711).
Arabic العربية	اتصل على الرقم 1-833-644-1621 (الهاتف النصي (TTY): 711) لتلقي خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإضافية.
Serbo-Croatian Srpski	За бесплатну помоћ у вези са језиком и помагала и услуге, позовите 1-833-644-1621 (TTY: 711).
Japanese 日本語	無料の言語サポートや補助器具・サービスをご希望の方は、1-833-644-1621（TTY: 711）までお電話ください。
French Français	Pour bénéficier de services d'assistance linguistique gratuits, ainsi que de services et aides complémentaires, appelez le 1-833-644-1621 (ATS : 711).
Korean 한국인	무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면1-833-644-1621 (TTY: 711)로 연락 주시기 바랍니다.
Pennsylvanian Dutch Pennsylvanisch Deitsche	Fer koschdenlos Schprooch Helfe, un annere Helfe un Services, ruff 1-833-644-1621 (TTY: 711).
Nepali नेपाली	भाषासम्बन्धी निःशुल्क सहायता सेवा र अतिरिक्त सहायता तथा सेवाहरूका लागि 1-833-644-1621 (TTY: 711) मा कल गर्नुहोस्।
Cushite Afaan Oromoo	Tajaajiloota hiikkaa afaanii, fi namoota hanqina dhagahuu qabaniif deeggarsa dhageettii meeshaatiinii bilisaan argachuuf, gara 1-833-644-1621 (TTY: 711) tti bilbilaa.
Russian Русский	Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-833-644-1621 (телетайп: 711).
Tagalog	Para sa libreng serbisyo sa tulong sa wika, at mga auxiliary aid at serbisyo, tumawag sa 1-833-644-1621 (TTY: 711).
Bantu Ikirundi	Kugira uronke serevise y'ugufasha mu vy'indimi, n'ubufasha na serevise ku bafise ingorane z'ukwumva, tera akamo x-xxx-xxx-xxxx (TTY: 711).