

JULY 1, 2019

SPD SUPPLEMENT

Oxford Health Plan
Motion Picture Industry Health Plan

Table Of Contents

2 SECTION 1 Introduction	15 ⑧ Other Reconstructive & Corrective Surgery	E Mental Health Care and Substance Use Services
2 SECTION 2 Telephone and Address Reference Guide	15 ⑨ Oral Surgery	23 ① Mental Health Care Services
3 SECTION 3 How the Plan Works	16 ⑩ Laboratory Procedures, Diagnostic Testing, Radiology Services and X-ray Exams	24 ② Substance Use Services
3 Getting Started	16 ⑪ Internal and External Prosthetic Devices	25 SECTION 6 Exclusions and Limitations
3 Cost-Sharing Expenses and Eligible Expense	17 ⑫ Durable Medical Equipment and Braces	32 SECTION 7 Participant Rights and Responsibilities
4 How Your Coverage Works	17 ⑬ Medical Supplies	33 SECTION 8 Claims Procedures
7 Selecting a Primary Care Physician	17 ⑭ Transplants	37 SECTION 9 Coordination of Benefits
7 Provider Participation and Transitional Care	18 ⑮ Home Health Care	40 SECTION 10 Subrogation and Reimbursement
8 Patient/Provider Relationship	18 ⑯ Chemotherapy	44 SECTION 11 Other Important Information
8 Provider Reimbursement	18 ⑰ Second Opinions	47 SECTION 12 Glossary
10 SECTION 4 Plan Highlights	18 ⑱ Chiropractic Services	54 ATTACHMENT I Gym Reimbursement
Summary of Coverage	18 ⑲ Clinical Trials for Cancer or Disabling or Life Threatening Chronic Disease	54 ATTACHMENT II Hemophilia Factor Benefits
12 SECTION 5	20 ⑳ Hearing Aids	56 ATTACHMENT III Nondiscrimination and Accessibility Requirements
A Preventive Care	20 ㉑ Dialysis	
12 ① Diabetic Equipment, Supplies and Education	20 ㉒ Gender Dysphoria	
13 ② Health Education	20 ㉓ Cellular and Gene Therapy	
B Specialty Care	C Hospital and Other Facility-Based Services	
13 ① Surgical and Obstetrical Services	21 ① Hospital Services	
13 ② Maternity and Newborn Care	22 ② Ambulatory Surgery Center	
14 ③ Treatment of Infertility	22 ③ Skilled Nursing Facility	
15 ④ Allergy Testing and Treatment	22 ④ Hospice	
15 ⑤ Habilitation Services	D Emergencies	
15 ⑥ Rehabilitation Services	22 ① Hospital Emergency Room Visits	
15 ⑦ Reconstructive Breast Surgery	23 ② Emergency Hospital Admissions	
	23 ③ Ambulance Services	
	23 ④ Payments Relating to Emergency Services Rendered	
	23 ⑤ Urgent Care	

SECTION 1

Introduction

The Motion Picture Industry Health Plan (“Plan” or “Plan Administrator”) is pleased to provide you with this Summary Plan Description Supplement (“Supplement”), which describes the health benefits available to you and your covered family members through Oxford Health Plan (“Oxford”). It includes summaries of:

- ▶ services that are covered, called Covered Services;

- ▶ services that are not covered, called Exclusions;
- ▶ how benefits are paid; and
- ▶ your rights and responsibilities under the Plan.

This document is intended to supplement the Summary Plan Description for the Motion Picture Industry Health Plan for Active Participants (“SPD”).

Oxford is a private healthcare claims administrator. Although Oxford will assist you in many ways, it does not guarantee any benefits. The Plan, is solely responsible for paying benefits described in this Supplement.

Please read this Supplement thoroughly to learn how Oxford works. If you have questions, contact Oxford or call the number on the back of your ID card.

SECTION 2

Telephone and Address Reference Guide

There are several ways to contact Oxford, Oxford’s website, www.oxhp.com, is available 24 hours a day, seven days a week to obtain answers to your questions. If you need to reach Oxford by mail or telephone, it is important for you to know how. The following is a list intended to make your interactions with Oxford a little bit easier!

CUSTOMER SERVICE REPRESENTATIVES

Available
Monday - Friday
8:00 a.m. to 6:00 p.m.
(800) 444-6222 or
the number on the
back of your ID card

MEDICAL EMERGENCIES AND URGENT CARE

Medical Management
Coordinator
(800) 444-6222 or
After 5:00 p.m.:
(800) 201-4911

PREAUTHORIZATION

(800) 444-6222

BEHAVIORAL HEALTH

(800) 201-6991

1ST LEVEL STANDARD GENERAL ADMIN AND CLINICAL APPEALS

Submit claim forms to:

Oxford
P.O. Box 30432
Salt Lake City,
UT 84130-0432
(800) 444-6222 or
After 5:00 p.m.:
(800) 201-4911

2ND LEVEL STANDARD GENERAL ADMIN AND CLINICAL APPEALS

Submit claim forms to:

Motion Picture Industry Health Plan
Attn: Benefits/
Appeals Committee
P.O. Box 1999
Studio City, CA 91614

EXTERNAL REVIEW

Oxford External Appeals Request Department

P.O. Box 29139
Hot Springs, AR 71903
(800) 444-6222 or
After 5:00 p.m.:
(800) 201-4911
Fax: (877) 814-8620

How The Plan Works

GETTING STARTED

This document contains a detailed description of the benefits available to you through Oxford. You should be familiar with all of the terms and conditions. This Supplement determines what coverage you have and what amounts Oxford will pay.

You are provided access to Covered Services from Providers within Oxford's Freedom Network, which is Oxford's largest network. You can choose to receive Covered Services from Oxford's Freedom In-Network Providers, or you can receive Covered Services from Freedom Out-of-Network Providers.

Your out-of-pocket responsibility differs depending upon whether Covered Services are obtained through your In-Network or Out-of-Network Benefits. Generally, you will be responsible for paying a higher portion of your medical expenses when you obtain Out-of-Network Benefits.

COST-SHARING EXPENSES AND ELIGIBLE EXPENSES

Your share of the costs will depend on the following:

1 Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Out-of-Network Covered Services before you are eligible to begin receiving benefits. The amounts you pay toward your Annual Out-of-Network Deductible accumulate over the course of the calendar year. Any charges of an Out-of-Network Provider that are

in excess of the Eligible Expense do not apply toward the Annual Deductible.

Except where stated otherwise, you must pay the amount in the Schedule of Benefits section of this Supplement for Covered Services before the Plan provides coverage.

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

2 Co-payment

A Co-payment is the amount you pay each time you receive certain Covered Services. The Co-payment is a flat dollar amount and is paid at the time of service or when billed by the Provider. Co-payments do not count toward the Out-of-Pocket Maximum. Co-payments do not count toward the Annual Deductible. If the Eligible Expense is less than the Co-payment, you are only responsible for paying the Eligible Expense and not the Co-payment.

3 Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying for Out-of-Network Covered Services. Coinsurance is a fixed percentage that applies to certain Covered Services after you meet the Annual Deductible.

Coinsurance – Example

Let's assume that you undergo outpatient surgery from an Out-of-Network Provider. Since the Plan pays 70% after you meet the Annual Deductible, you are responsible for paying the other 30%. This 30% is your Coinsurance.

4 Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Services. If your eligible Out-of-Pocket expenses in a calendar year exceed the annual maximum, Oxford pays 100% of Eligible Expenses for Covered Services through the end of the calendar year.

Any charges of an Out-of-Network Provider that are in excess of the Eligible Expense do not apply toward your Out-of-Pocket Maximum.

Cost-sharing for In-Network services does not apply toward your Out-of-Network Out-of-Pocket Limit. The Preauthorization penalty described in the How Your Coverage Works section of this Supplement does not apply toward Your Out-Network Out-of-Pocket Limit. The Out-of-Network Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.

Your Additional Payments for Out-of-Network Benefits

When you receive Covered Services from an Out-of-Network Provider, in addition to the applicable Co-Payments, Coinsurance, and Deductible, shown in the *Plan Highlights* section of this Supplement, you must also pay the amount, if any, by which the Out-of-Network Provider's actual charge exceeds the Eligible Expense. This means that the total of Oxford's coverage and any amounts you pay under your applicable Deductible, Co-Payment, and Coinsurance may be less than the Out-of-Network

Provider's actual charge.

When you receive Covered Services from an Out-of-Network Provider, Oxford will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis code for the services you received. Sometimes, applying these rules will change the way that Oxford pays for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently.

As an example, your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. Oxford will make one inclusive payment in that case, rather than a separate payment for each billed code. Another example of when Oxford will apply the payment rules to a claim is when you have surgery that involves two surgeons acting as "co-surgeons". Under the payment rules, the claim from each Provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If Oxford receives a claim that does not have the correct modifier, Oxford will change it and make the appropriate payment.

5 Eligible Expenses

"Eligible Expenses" means the maximum amount the Plan will pay to a Provider for the services or supplies covered under this Plan, before any applicable Deductible, Co-Payment, and Coinsurance amounts are subtracted. Oxford determines the Eligible Expenses as follows:

In-Network Providers

The Eligible Expense for In-Network Providers will be the amount Oxford has negotiated with the In-Network Provider.

Out-of-Network Providers

The Eligible Expense for Out-of-Network Providers will be determined as follows:

1 Facilities

For Facilities, the Eligible Expense will be 70% of the Fair Health rate.

2 For All Other Providers

For all other Providers, the Eligible Expense will be 70% of the Fair Health rate.

3 Physician-Administered Pharmaceuticals

For Physician-administered pharmaceuticals, Oxford uses gap methodologies that are similar to the pricing methodology used by the Centers for Medicare and Medicaid Services, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or Oxford based on an internally developed pharmaceutical pricing resource if the other methodologies have no pricing data available for a Physician-administered pharmaceutical or special circumstances support an upward adjustment to the other pricing methodology.

If there is no amount as described above, the Eligible Expense will be 50% of the Provider's charge.

Don't Forget Your ID Card

Remember to show your Oxford ID card every time you receive health care services from a Provider.

HOW YOUR COVERAGE WORKS

1 In-Network Services

You may seek primary preventative or specialty care from any In-Network Provider with a referral. You and your eligible Dependents are still required to select a Primary Care Physician (PCP). If you select a PCP when you enroll, Oxford encourages you to use your PCP when you need primary or preventive care. Oxford encourages you to allow your PCP to coordinate your specialty care needs. In this manner, continuity of care can be maintained.

To receive the highest level of benefits, contact an In-Network Physician when you need medical assistance. In most instances, he or she will be able to provide the care you need. If you require services from another Provider, be sure that he or she is also an In-Network Provider by checking the roster of In-Network Providers, or by calling Oxford.

Except for emergencies, and Preauthorized visits to Out-of-Network Providers, only services provided by an In-Network Provider are covered on an In-Network basis.

If an In-Network Provider recommends hospital or surgical services, they will need an "okay" from Oxford before you obtain those services. This process is referred to as Preauthorization. Before entering the hospital, you may want to check with Oxford's

Customer Service to verify that the hospital is an In-Network Provider and that the services have been Preauthorized.

Looking for an In-Network Provider?

In addition to other helpful information, Oxford's consumer website, www.oxhp.com, contains a directory of health care professionals and facilities in Oxford's network. While In-Network status may change from time to time, visit Oxford's website, www.oxhp.com, for the most current source of In-Network information, and search for Providers available in your Plan.

2 Out-of-Network Services

If you decide you do not want to use an In-Network Provider, Oxford still provides coverage for a broad range of medical services. However, Covered Services not obtained from In-Network Providers will be subject to Deductible, Coinsurance and the amount, if any, by which the Out-of-Network Provider's actual charge exceeds the Eligible Expenses. This means that the total of the Oxford coverage and any amounts you pay under your applicable Deductible, Co-Payment, and Coinsurance may be less than the Out-of-Network Provider's actual charge. Further, Out-of-Network Providers may not be familiar with the Oxford's plan. Therefore, you should review the "Covered Services" and "Limitations and Exclusions" sections of this Supplement. You may also contact Customer Service if you have any questions concerning Covered Services. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to In-Network and Out-of-Network services.

Surgical procedures and hospitalizations still require Preauthorization. You are responsible for obtaining any required Preauthorization. You must call (or have your Physician call) customer service to obtain the Preauthorization. Failure to Preauthorize will result in a 50% reduction in benefits.

In-Network Exceptions

If an In-Network Provider cannot perform or deliver the Covered Services you need, you may receive In-Network coverage for Medically Necessary Covered Services from an Out-of-Network Provider. First, you must contact Oxford and preauthorize the use of an Out-of-Network Provider. Before preauthorizing the use of an Out-of-Network Provider for In-Network Covered Services, Oxford may recommend another In-Network Provider who is able to render the services you need. However, if Oxford agrees that it is necessary for you to use an Out-of-Network Provider (and Preauthorize the services), there will be no additional cost to you beyond your required Co-Payment.

Additionally, Preauthorization requests for admissions to Out-of-Network facilities (e.g., hospitals, rehabilitation centers) to be covered on an In-Network basis will not be approved unless Oxford agrees that an In-Network facility is unable to meet your specific medical needs. While you and your In-Network Provider may discuss having a procedure performed at a specific Out-of-Network facility, In-Network coverage is only available if Oxford agrees that the procedure cannot be safely performed at any In-Network facility. Any non-emergency Covered Services

received at an Out-of-Network facility will be subject to the Out-of-Network level of benefits.

3 Preauthorization

Preauthorization Procedure

If you seek coverage for Out-of-Network services that require Preauthorization you must call Oxford at the number indicated on your ID card. After receiving a request for approval, Oxford will review the reasons for your planned treatment and determine if benefits are available. Criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

Failure to Seek Preauthorization

If you fail to seek Preauthorization for benefits subject to this section or as described in the Schedule of Benefits of this Supplement, the amount that Oxford would otherwise have paid for the care will be reduced by 50%. You must pay the remaining charges. Oxford will pay the amount specified above only if it is determined the care was Medically Necessary even though you did not seek Preauthorization. If it is determined that the services were not Medically Necessary, you will be responsible for paying the entire charge for the service. Refer to your Schedule of Benefits to determine the Preauthorization Penalty that applies.

Medical Management

The benefits available to you under this Supplement are subject to pre-service, concurrent and retrospective reviews to determine when services should be covered. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place

of service that they are performed. Covered Services must be Medically Necessary for benefits to be provided.

4 Medical Necessity

Oxford covers benefits described in this Supplement as long as the health care service, procedure, treatment, test, device, prescription drug or supply (collectively, “service”) is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that Oxford has to cover it.

Oxford may base its decision on a review of:

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

Services will be deemed Medically Necessary only if:

- ▶ They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for your illness, injury, or disease;
- ▶ They are required for the direct care and treatment or management of that condition;
- ▶ Your condition would be adversely affected if the services were not provided;
- ▶ They are provided in accordance with generally-accepted standards of medical practice;
- ▶ They are not primarily for the convenience of you, your family, or your Provider;
- ▶ They are not more costly than an alternative service or sequence of services, that is they are at least as likely to produce equivalent therapeutic or diagnostic results. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, Oxford will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis, or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a Physician’s office or the home setting.

See the section on *Claims Procedures* in this Supplement for your right to an internal appeal and/or external appeal of Oxford’s determination that a service is not

Medically Necessary.

5 Second Opinions

Oxford reserves the right to require a second opinion for any surgical procedure. At the time of Preauthorization, you may be advised that a second opinion will be required in order for the services to be covered. If a second opinion is required, Oxford will refer you to an In-Network Provider for a second opinion.

In the event that the first and second opinions differ, a third opinion will be required. Oxford will designate a new In-Network Provider. The third opinion will determine whether or not the surgery is Preauthorized. There will be no cost to you for the second or third opinion. You may also request a second opinion.

6 Emergencies

If you have an emergency, you should obtain medical assistance immediately or call 911. Emergency room care is not subject to Oxford’s prior approval. **However, only emergencies, as defined in this Supplement, are Covered in an emergency room.** Therefore, before you seek treatment, you may want to be certain that this is the most appropriate place to receive care. Call Oxford’s medical management coordinators. They are available 24 hours a day, 7 days a week. The coordinator will direct you to the emergency room of a hospital or other appropriate facility.

7 Urgent Care

For In-Network coverage, you must call Oxford’s medical management coordinators and follow the instructions you are given. When this procedure is followed, your Urgent Care will be covered in full,

less any required Co-Payment. This coverage will be provided regardless of where you are (in or out of the Service Area) when the need for Covered Services occurs.

If you do not call first, coverage will only be available on an Out-of-Network basis.

8 Diagnostic Testing and Laboratory Services

If your In-Network Provider recommends laboratory testing, remind him or her to use an In-Network Provider. In addition, covered x-rays or diagnostic procedures performed at In-Network facilities will be covered by the Plan without any required Co-Payment. Unless you are hospitalized, hospitals are not In-Network Providers for these tests.

9 Customer Service

All coverage is subject to the terms and conditions contained in your Plan documents. You should understand your rights and obligations before you obtain services. If you have questions, customer service will be pleased to help you.

10 Standing Referrals

Participants who need ongoing Specialty Care may receive a "standing referral" to an In-Network Specialist. Oxford's Medical Director will consult with your PCP and In-Network Specialist to determine if such a referral is appropriate. The referral will be provided pursuant to a treatment plan that has been approved by Oxford's Medical Director. Please note that the treatment plan may limit the amount of visits or the period of time during which the visits must occur. Further, the treatment plan may require the In-Network Specialist provide your

PCP with regular updates on the care being provided. You, your PCP or your In-Network Specialist may call Medical Management and request a standing referral.

Additionally, Participants who have a life-threatening condition or disease and Participants who have a degenerative and disabling condition or disease may request a standing referral to an In-Network Specialty Care Center. This referral is available only if the condition or the disease requires specialized medical care over a prolonged period of time. Further, the center must have the necessary medical expertise and be properly accredited or designated (as required by state or federal law or a voluntary national health organization) to provide the Medically Necessary care required for the treatment of the condition or disease. The services to be provided will be covered only to the extent they are otherwise covered under this Supplement.

11 More Information

As a Participant, you automatically receive a Supplement. Please note, you can request additional information about Oxford and your coverage under this Supplement.

SELECTING A PRIMARY CARE PHYSICIAN

1 Selecting Your PCP

As described, you are required to select a Primary Care Physician (PCP) when you enroll. Please refer to the roster of In-Network Providers when selecting a PCP.

2 Primary Provider of OB/GYN Care

In addition to a PCP, female

Participants should select an In-Network Provider of OB/GYN care.

3 In-Network Specialists as PCPs

Participants who have a life-threatening condition or disease and Participants who have a degenerative and disabling condition or disease may request to elect an In-Network Specialist as their PCP. The designated In-Network Specialist will become responsible for providing and coordinating all of the Participant's Primary Care and Specialty Care. He or she will be able to order tests, arrange procedures and provide referrals and medical services in the same capacity as a PCP.

This election is available only if the condition or disease requires specialized medical care over a prolonged period of time. The desired In-Network Specialist must have the necessary qualifications and expertise to treat the Participant's condition or disease. A Participant may request this election at the time of enrollment or upon diagnosis.

4 Changing Your PCP

If you selected a PCP when you enrolled, you may change your PCP (or Provider of OB/GYN care) at any time. Select a new Provider from the roster of Oxford's In-Network Physicians then call customer service to update your selection. The change will become effectively immediately.

PROVIDER PARTICIPATION AND TRANSITIONAL CARE

1 Provider Participation

Oxford cannot promise that a specific Provider, even though

listed in the roster of In-Network physicians, will be available. An In-Network Provider may end his or her contract with Oxford, or decide not to accept additional patients. If you have any questions about whether or not a particular Provider is currently In-Network or accepting new patients, please feel free to call Oxford's customer service and inquire. If your PCP or In-Network Specialist leaves Oxford's network, you should choose another PCP or In-Network Specialist in order to continue receiving care on an In-Network basis. However, if you are undergoing a course of treatment at the time your In-Network Provider leaves the network, you may be eligible for Transitional Care as described below.

2 Transitional Care

Your Provider Leaves the Network

If you are undergoing a course of treatment when your Provider leaves the network, you may be able to continue to receive Covered Services for the ongoing treatment from your former In-Network Provider for up to ninety (90) days from the date your Provider's contractual obligation to provide services to you terminates. Regarding pregnancy, if the Provider leaves the network while you are in your second or third trimester, you may be able to continue care with a former In-Network Provider through delivery and any post-partum care directly related to the delivery.

In order for you to continue to receive Covered Services for up to ninety (90) days or through a pregnancy with a former In-Network Provider, the Provider must agree to accept as payment the negotiated fee that was in

effect just prior to the termination of Oxford's relationship with the Provider. The Provider must also agree to provide Oxford necessary medical information related to your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, referrals, and a treatment plan approved by Oxford. If the Provider agrees to these conditions, you will receive these Covered Services as if they are being provided by an In-Network Provider. You will only be responsible for any applicable In-Network cost-sharing. Please note that if the Provider was terminated by Oxford due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

New Participants Currently Undergoing a Course of Treatment

If you are undergoing a course of treatment with an Out-of-Network Provider at the time your coverage under this Supplement becomes effective, you may be able to receive Covered Services from the Out-of-Network Provider for up to 60 days from the effective date of your coverage under the Supplement. This coverage is available only if the course of treatment is for a life-threatening disease/condition or a degenerative and disabling disease/condition. Coverage is limited to the disease/condition. Regarding pregnancy, if your coverage becomes effective while you are in your second trimester or third trimester, you may receive Covered Services from your Out-of-Network Provider through delivery and any post-partum care directly

related to the delivery.

However, Transitional Care is available only if the Provider agrees to accept as payment Oxford's negotiated fees for such services. Further, the Provider must agree to adhere to all of Oxford's quality assurance procedures as well as all other policies and procedures required by Oxford regarding the delivery of Covered Services. If the Provider agrees to these conditions, you will receive these Covered Services as if they are being provided by an In-Network Provider. You will only be responsible for any applicable Co-Payments.

In order to obtain Transitional Care, you or your Provider should call Medical Management at (800) 444-6222 and request this coverage.

PATIENT/PROVIDER RELATIONSHIP

In-Network Providers are solely responsible for all health services that you receive. If you refuse to follow a recommended treatment, and the In-Network Provider believes that no professionally acceptable alternative exists, you will be so advised. In such a case, subject to the second opinion process, neither Oxford nor the In-Network Provider will have any further responsibility to provide benefits for the condition under treatment.

PROVIDER REIMBURSEMENT

Reimbursement

The Plan reimburses our In-Network Providers in a variety of ways. The most common is a discount off the Provider's usual

fee. This means the Provider agrees to accept less than what he or she would usually be paid for that service. In return, the Provider's name appears in Oxford's roster, which gives the Provider an opportunity to gain new patients from among our membership.

SECTION 4

Plan Highlights

SUMMARY OF COVERAGE		IN-NETWORK	OUT-OF-NETWORK
Financial	Single Deductible	None	\$500
	Family Deductible	None	\$1,000
	Coinsurance	None	30%
	Maximum Out-of-Pocket (Single)	None	\$8,000
	Maximum Out-of-Pocket (Family)	None	\$16,000
Lifetime Maximum Benefit: There is no dollar limit to the amount Oxford will pay for essential benefits during the entire period you are enrolled in this plan.			
Preventive Care	Adult Preventive Care	No Charge	In-Network Benefit Only
	Infant and Pediatric Preventive Care	No Charge	Deductible & 30% Coinsurance
Outpatient Care	Primary Care Physician Office Visits	\$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Specialist Office Visits	\$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Outpatient Facility Surgery**	No Charge	Deductible & 30% Coinsurance
	Laboratory Services	At In-Network Laboratories: No Charge	Deductible & 30% Coinsurance
	MRIs, MRAs, PET Scan, CT Scan, Ultrasound**	No Charge	Deductible & 30% Coinsurance
	Radiology Services**	No Charge	Deductible & 30% Coinsurance
Hospital Care	Physician's and Surgeon's Services**	No Charge	Deductible & 30% Coinsurance
	Semi-Private Room and Board**	No Charge	Deductible & 30% Coinsurance
	All Drugs and Medications	No Charge	Deductible & 30% Coinsurance
Emergency Care	Ambulance Service When Medically Necessary	No Charge	Deductible & 30% Coinsurance
	At Hospital Emergency Room (If member is admitted to the hospital, notification is required)	\$25 Co-Payment, waived if admitted	\$25 Co-Payment, waived if admitted
	Urgent Care Center	\$15 Co-Payment per visit	Deductible & 30% Coinsurance
Maternity Care	Routine Prenatal and Post-Natal Care**	No Charge	Deductible & 30% Coinsurance
	Hospital Services for Mother and Child**	No Charge	Deductible & 30% Coinsurance
Skilled Nursing Facility	Unlimited Days**	No Charge	Deductible & 30% Coinsurance
Hospice Care	Inpatient Care**	No Charge	Deductible & 30% Coinsurance
	Home Hospice**	\$15 Co-Payment per visit	Subject to a 20% Coinsurance
Home Health Care	60 Home Care Visits**	\$15 Co-Payment per visit	Subject to a 20% Coinsurance
	Physician House Calls	\$15 Co-Payment per visit	Deductible & 30% Coinsurance

**Preauthorization upon initial visit

Preauthorization Penalty In-Network: Preauthorization is the responsibility of the In-Network Provider. Out-of-Network: The Services that require Preauthorization from Out-of-Network Providers are reflected in this document. If you fail to obtain a required Preauthorization for an Out-of-Network benefit, you must pay 50% of the Eligible Expenses (Allowed Amount).

SUMMARY OF COVERAGE		NETWORK	OUT-OF-NETWORK
Hemophilia Factor Benefits		\$15 Co-Payment per visit	Not Covered
Substance Use Disorder Services	Inpatient Substance Use Services**	No Charge	Deductible & 30% Coinsurance
	Outpatient Substance Use Services	\$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Office Visits**	\$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Partial Hospitalization & Intensive Outpatient Program Services	\$15 Co-Payment per visit	Deductible & 30% Coinsurance
Mental Health Care	Inpatient Care**	No Charge	Deductible & 30% Coinsurance
	Outpatient Care	\$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Office Visits	\$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Partial Hospitalization & Intensive Outpatient Program Services	\$15 Co-Payment per visit	Deductible & 30% Coinsurance
Allergy Care	Testing, Allergy Clusters and Treatment	\$15 Co-Payment per visit	Deductible & 30% Coinsurance
Chiropractic Care		\$15 Co-Payment per visit	Deductible & 30% Coinsurance
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	60 Consecutive Inpatient Days per Condition/Lifetime	No Charge	Deductible & 30% Coinsurance
	90 Outpatient Visits per Condition/Lifetime	\$15 Co-Payment per visit	Deductible & 30% Coinsurance
Short Term Rehabilitation	Inpatient - Unlimited**	No Charge	Deductible & 30% Coinsurance
	Outpatient - Unlimited **	\$15 Co-Payment per visit	Deductible & 30% Coinsurance
Durable Medical Equipment** (Preauthorization required for items over \$500)		No Charge (When ordered by an Oxford In-Network Physician)	Deductible & 30% Coinsurance
Medical Supplies When Medically Necessary		Out-of-Network Benefit Only	Deductible & 30% Coinsurance
Exercise Facility	Participant	\$200 Reimbursement per 6-month period	\$200 Reimbursement per 6-month period
	Spouse	\$100 Reimbursement per 6-month period	\$100 Reimbursement per 6-month period
Elective Termination of Pregnancy (\$350 maximum for one procedure per Member per Calendar Year)		No Charge	Deductible & 30% Coinsurance
Advanced Infertility Treatment (\$10,000 per lifetime)	Specialist Office Visits**	\$15 Co-Payment per visit	In-Network Benefit Only
	Inpatient Facility Services**	No Charge	In-Network Benefit Only
	Outpatient Facility Services**	No Charge	In-Network Benefit Only
Transgender	Specialist Office Visits**	\$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Facility Services**	No Charge	Deductible & 30% Coinsurance
Hearing Aids	Limited to a single purchase (including repair/replacement) every 3 years	No Charge	Deductible & 30% Coinsurance

**Preauthorization upon initial visit

Covered Services

WHAT THIS SECTION INCLUDES:

- ▶ Covered Services for which Oxford pays benefits.

You will receive Covered Services in accordance with the terms and conditions of this Supplement only when the Covered Service is:

- ▶ Medically Necessary;
- ▶ properly Preauthorized, when required;
- ▶ received while your coverage is in force;
- ▶ not excluded under this Supplement; and
- ▶ not in excess of the benefit limitations described in this Supplement.

All Covered Services are subject to the Co-Payments, Coinsurance and Deductibles specified under the *Plan Highlights*. All reimbursement for services rendered by Out-of-Network Providers is subject to Out-of-Network Reimbursement Amounts.

Except for emergencies, Preauthorized Urgent Care, or when Oxford Precertifies the use of an Out-of-Network Provider any Covered Service you obtain from an Out-of-Network Provider will be Covered on an Out-of-Network basis.

Important

Oxford reserves the right to provide benefits in the manner it determines to be the most cost effective. Based on Oxford's medical policies, Oxford reserves the right to provide benefits in the manner, and to the extent, Oxford

believes is Medically Necessary.

Primary Care consists of office visits, house calls and hospital visits provided by your Provider for consultations, diagnosis and treatment of medical conditions, injury and disease that do not require the services of a specialist.

Preventive Care consists of the following services, performed by your Provider for the purpose of promoting good health and early detection of disease.

A PREVENTIVE CARE

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

- ▶ evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*;
- ▶ immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*;
- ▶ with respect to infants, children and adolescents, evidence-

informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration (HRSA)*;

- ▶ with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *HRSA*; and
- ▶ with respect to women, preventive care benefits defined under the *HRSA* requirement include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a Durable Medical Equipment Provider or Physician.

① DIABETIC EQUIPMENT, SUPPLIES AND EDUCATION

Diabetic supplies, education and self-management are covered as follows:

Supplies

The following equipment and related supplies will be covered for insulin dependent and non-insulin dependent Participants when Medically Necessary as determined by the Participant's Physician:

- ▶ Acetone Reagent Strips
- ▶ Acetone Reagent Tablets
- ▶ Alcohol Wipes
- ▶ All insulin preparations
- ▶ Automatic Blood Lance Kit

- ▶ Blood Glucose Kit
- ▶ Blood Glucose Strips (Test or Reagent)
- ▶ Blood Glucose Monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor (models with special features for the visually impaired must be Preauthorized by Oxford's Medical Director)
- ▶ Cartridges for the visually impaired Diabetes data management systems
- ▶ Disposable insulin and pen cartridges
- ▶ Drawing-up devices for the visually impaired
- ▶ Equipment for use of the pump
- ▶ Glucose Acetone Reagent Strips
- ▶ Glucose Reagent Strips
- ▶ Glucose Reagent Tape
- ▶ Injection Aides
- ▶ Injector (Busher) Automatic
- ▶ Insulin Cartridge Delivery
- ▶ Insulin Infusion Devices (Preauthorization is required for this item)
- ▶ Insulin pump
- ▶ Lancets
- ▶ Oral agents such as glucose tablets or gels
- ▶ Syringe with needle; sterile 1 cc box
- ▶ Urine testing products for glucose and ketones

Additional items may also be covered if the Participant's Physician determines they are Medically Necessary and prescribes them for the Participant.

Such additional items must be Preauthorized by one of Oxford's Medical Directors and be in accordance with the treatment plan developed by the Physician for the Participant.

Self-Management and Education

Education on self-management and treatment of diabetes is covered:

- ▶ upon the initial diagnosis;
- ▶ if there is a significant change in the Participant's condition; or
- ▶ the Physician decides that a refresher course is necessary. It must be provided:
 - In a Physician's office either by the Physician or his/her qualified nurse during an office visit or in a group setting.
 - Upon a Physician's referral to the following non-Physician, medical educators (qualified health Providers): certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians.
 - Whenever possible, in a group setting, regardless of whether the Provider is a Physician or a qualified health Provider. Education will also be provided in the Participant's home if the Participant is homebound.

② HEALTH EDUCATION

Health education, information and health care literature which is made available to Participant's through various programs provided and developed by Oxford. These programs and information are provided without cost to Participants. Such programs include Oxford's Healthy Mother, Healthy Baby Program; Oxford's Better Breathing Program and

Oxford's Healthy Mind, Healthy Body magazine.

B SPECIALTY CARE

Specialty Care consists of medical care and services, including office visits, house calls, hospital visits and consultations for the diagnosis and treatment of disease or injury as described below.

Please note

Most Specialty Care services require Preauthorization.

① SURGICAL AND OBSTETRICAL SERVICES

****Preauthorization required for certain services***

Physicians' services for surgical and obstetrical procedures on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant, and anesthesiologist together with preoperative and postoperative care. Deliveries and related services that are performed by a certified nurse midwife are also covered.

Hospital admissions, including maternity admissions, require Preauthorization. When possible, the Preauthorization should be obtained at least 14 days in advance of the service.

② MATERNITY AND NEWBORN CARE

Maternity Care

Services and supplies for maternity care provided by a Physician, licensed nurse midwife, hospital or birthing center will be covered for prenatal care (including one visit for genetic testing), postnatal care, delivery and complications of pregnancy. Oxford provides a minimum inpatient stay of 48 hours following a vaginal delivery

and 96 hours following a cesarean delivery for both the mother and the newly born child or children. While in the hospital, maternity care also includes, at a minimum, parent education, assistance and training in breast or bottle-feeding and the performance of any necessary maternal and newborn clinical assessments. Unless the admission to the hospital or birthing center is made on an emergency basis, the admission must be Preauthorized.

The mother has the option to leave the hospital sooner than described above. If she decides to be discharged early, she will be provided with one home visit. The home visit must be requested by the mother within 48 hours of a vaginal birth or within 96 hours of a cesarean birth. The visit will occur within 24 hours of the later of: the mother's request; or her discharge from the hospital. This visit is not subject to deductible or Co-Payment. Additionally, the visit will not be deducted from the Home Health Care visits covered under the Supplement.

The home visit consists of a visit by a professional RN to provide the following post-delivery care: an assessment of the mother and child, instruction on breastfeeding, cleaning and care for child; and any required blood tests ordered by either the mother's or the child's Physician.

In-Network coverage for a routine delivery or maternity care outside of the service area is limited. Oxford defines a "routine delivery" as a full-term delivery that has occurred without any complications. If you arrange to give birth at a facility outside of the service area, and the delivery is

routine, the service will be covered as an Out-of-Network benefit and will be subject to Deductible and Coinsurance. Oxford will assume that you have arranged to give birth at a facility outside of the service area if you travel to the area of the facility near the time of your delivery. In those instances where the Out-of-Network facility is near the service area, routine deliveries will be covered as an Out-of-Network benefit if you could safely have delivered in an In-Network facility. Exceptions will be made on a "case" by "case" basis if Oxford determines that circumstances beyond your control (such as a death in your family) required you to be outside of the service area at the time of your delivery.

Interruption of Pregnancy

Therapeutic abortions are covered. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Oxford covers elective abortions for one procedure per Participant, per calendar year.

Newborn Care

**Preauthorization required for certain services*

Care for newborns includes preventive health care services (including electrophysiologic screening measures and periodic monitoring of infants for delayed onset of hearing loss), routine nursery care, and treatment of disease and injury. Treatment of disease and injury includes treatment of prematurity and medically diagnosed congenital defects and birth abnormalities which cause anatomical functional impairment. Oxford also covers, within the limits of this Supplement, necessary transportation costs from the place

of birth to the nearest specialized treatment center.

**In-Network and Out-of-Network, routine nursery and preventive Newborn Care does not require Preauthorization*

Circumcision performed by a licensed medical practitioner during the delivery inpatient stay does not require Preauthorization. However, services that generally require Preauthorization (such as surgery) must be Preauthorized.

③ TREATMENT OF INFERTILITY

Basic Infertility Services

Basic Infertility Services will be provided to a Participant who, in Oxford's opinion, is an appropriate candidate for infertility treatment. Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram and medically appropriate treatment of ovulatory dysfunction with Clomiphene Citrate.

Comprehensive Infertility Services

If the Basic Services do not result in increased fertility, Medical Management may Preauthorize Comprehensive Infertility Services. These services include: ovulation induction and monitoring with ultrasound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy.

Advanced Infertility Services

Should the Comprehensive Infertility Services fail to increase fertility, Oxford's Medical Director may Preauthorize the following Advanced Infertility Services: in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT).

④ ALLERGY TESTING AND TREATMENT

Oxford covers testing, allergy clusters and evaluations, including injections, and scratch and prick tests to determine the existence of an allergy. Oxford covers allergy treatment, including desensitization treatments, routine allergy injections and serums.

⑤ HABILITATION SERVICES

Oxford covers Habilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a health care professional's office. Refer to your Schedule of Benefits to determine if a limit applies to your plan.

⑥ REHABILITATION SERVICES

Rehabilitation therapy including physical therapy, speech therapy, and occupational therapy, is covered on an outpatient or inpatient basis. Coverage on an outpatient basis is limited to the amount of visits shown in the *Plan Highlights*. For the purposes of this benefit (both inpatient and outpatient), "per condition" means the disease or injury causing the need for the therapy. For Covered Services received under this benefit you are eligible to receive up to the specified amount for the singular condition as noted in the *Plan Highlights*. The accumulation of this limit is based on the "condition" and not the therapy type. Unrelated conditions are subject to separate maximums. A "session" is a period of time, up to 45 minutes, in which therapy is performed.

Speech or occupational therapy is covered only when it is related to the treatment or diagnosis of your physical illness or injury (in

the case of a covered child, this includes a medically diagnosed congenital defect), it is ordered by a Physician and you have been hospitalized or have undergone surgery for such illness or injury.

Covered Services must begin within six months of the later to occur:

- ▶ the date of the injury or illness that caused the need for the therapy;
- ▶ the date the Participant is discharged from a hospital where surgical treatment was rendered; or
- ▶ the date outpatient surgical care is rendered.
- ▶ And in no event will the therapy continue beyond 365 days after such event.

⑦ RECONSTRUCTIVE BREAST SURGERY

**Preauthorization required for inpatient admissions*

Oxford covers breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by you and your attending Physician to be appropriate. Oxford also covers implanted breast prostheses following a mastectomy or partial mastectomy.

Breast reconstruction (including surgery on the healthy breast to restore and achieve symmetry) or

implanted breast prostheses are also covered following a covered mastectomy. Cosmetic surgery is not covered.

⑧ OTHER RECONSTRUCTIVE AND CORRECTIVE SURGERY

**Preauthorization required for inpatient admissions*

Reconstructive and corrective surgery is covered only when it is:

- ▶ Performed to correct a congenital birth defect of a child covered by Oxford which has resulted in a functional defect;
- ▶ Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part;
- ▶ Otherwise Medically Necessary.

The reconstructive or corrective surgery must be performed within two years of the surgery that was necessitated by the trauma, infection or disease.

Breast reconstruction (including surgery on the healthy breast to restore and achieve symmetry) or implanted breast prostheses are also covered following a covered mastectomy. Cosmetic surgery is not covered.

⑨ ORAL SURGERY

General dental services are not covered. The following limited dental and oral surgical procedures are covered in either an inpatient or outpatient setting:

- ▶ Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when the repair is not possible. Dental services

must be obtained within 12 months of the injury. Accidental injury does not include damage caused to a tooth while biting or chewing or the intentional misuse of the tooth.

- ▶ Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- ▶ Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- ▶ Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- ▶ Surgical/nonsurgical medical procedures for temporomandibular joint disorders (TMJ) and orthognathic surgery. Preauthorization is required.

Oral surgery, including the dental services described above, requires Preauthorization. When possible, please obtain the Preauthorization at least 14 days in advance of the surgery or procedure.

⑩ **LABORATORY PROCEDURES, DIAGNOSTIC TESTING, RADIOLOGY SERVICES AND X-RAY EXAMINATIONS**

Oxford covers x-ray and laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services when performed on an outpatient basis.

Major diagnostic procedures require Preauthorization

It is important that you do not seek the services of a laboratory or imaging center without Preauthorization. If you do, you will be responsible for the costs of such services. Please contact Oxford before you obtain any of the procedures listed in the *Plan Highlights*.

Screening for Prostate Cancer

Oxford covers an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. Oxford also covers standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer. This benefit is not subject to Co-Payments, Deductibles or Coinsurance when provided by an In-Network Provider.

⑪ **INTERNAL AND EXTERNAL PROSTHETIC DEVICES**

Internal Prosthetic Devices

Oxford covers surgically implanted prosthetic devices and special appliances will be covered if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by you and your attending Physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal

wear and tear. Coverage does not include artificial organs.

External Prosthetic Devices

Oxford covers prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Oxford covers wigs only when you have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). Oxford does not cover wigs made from human hair unless you are allergic to all synthetic wig materials.

Oxford does not cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. For your other dental benefits, see the Motion Picture Industry Health Plan SPD for Active Participants.

Eyeglasses and contact lenses are not covered by Oxford. For your vision benefits, see the Motion Picture Industry Health Plan SPD for Active Participants.

Oxford does not cover orthotics (e.g., shoe inserts).

For adults, Oxford covers the cost of only one prosthetic device, per limb, per lifetime. For children, the cost of replacements is also covered but only if the previous device has been outgrown.

Coverage is for standard equipment only. Oxford does not otherwise cover the cost of repairs or replacement.

For adults, Oxford covers the cost of only one prosthetic device, per limb, per lifetime. For children,

the cost of replacements is also covered but only if the previous device has been outgrown.

Oxford covers external breast prostheses following a covered mastectomy, which are not subject to any lifetime limit.

12 DURABLE MEDICAL EQUIPMENT AND BRACES

**Preauthorization is required for the purchase of Durable Medical Equipment or braces is required when the item will cost \$500.00 or more.*

Durable Medical Equipment

Oxford covers the rental or purchase of durable medical equipment and braces. Durable Medical Equipment is equipment which is:

- ▶ designed and intended for repeated use;
- ▶ primarily and customarily used to serve a medical purpose;
- ▶ generally not useful to a person in the absence of disease or injury; and
- ▶ is appropriate for use in the home.

Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Oxford does not cover the cost of repairs or replacement that are the result of misuse or abuse by you. Oxford will determine whether to rent or purchase such equipment.

Customized or motorized equipment, or equipment designed for your comfort or convenience (such as pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment) are not

covered as they do not meet the definition of durable medical equipment. Oxford does not cover customization of any item of Durable Medical Equipment.

Braces

Oxford covers braces that are worn externally and that temporarily or permanently assists all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. Replacements are covered when growth or a change in the Participant's medical condition make replacement Medically Necessary. Oxford does not otherwise cover the cost of repairs or replacement (e.g., Oxford does not cover repairs or replacement that is the result of misuse or abuse by the Participant).

13 MEDICAL SUPPLIES

Oxford covers medical supplies that are required for the treatment of a disease or injury which is covered under this Supplement. Maintenance supplies (e.g., ostomy supplies) for conditions covered under this Supplement. All such supplies must be Medically Necessary and in the appropriate amount for the treatment or maintenance program in progress. Oxford does not cover over-the-counter medical supplies. Diabetic Supplies are not covered under this provision. Please see the "Diabetic Supplies, Education and Self-Management" section of this Supplement for a description of diabetic supply coverage.

14 TRANSPLANTS

Oxford covers only those transplants that Oxford determines to be non-experimental and

non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants (including CAR-T cell therapy for malignancies) for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by your Specialist(s) and Preauthorized by Oxford's Medical Director. Additionally, all transplants must be performed at hospitals that Oxford has specifically approved and designated to perform these procedures.

Oxford will cover the hospital and medical expenses, including donor search fees, of the recipient. Oxford will cover transplant services required by a Participant when the Participant serves as an organ donor only if the recipient is a Participant. Oxford does not cover medical expenses of a non-Participant acting as a donor for a Participant are not covered if the non-Participant's expenses will be covered under another health plan or program. Donor costs related to transplantation are covered services and are payable through the organ recipient's coverage under the Plan, limited to donor: (i) identification, (ii) evaluation, (iii) organ removal, and (iv) direct follow-up care.

Oxford will cover autologous bone marrow transplants combined with high dose chemotherapy when medically appropriate, for the treatment of: advance neuroblastoma, second remission acute leukemia, relapsed Hodgkin's disease, relapsed non-Hodgkin's lymphoma, and metastatic breast

cancer or any other diagnosis that Oxford determines to be appropriate. Oxford will make the determination of when such treatment is medically appropriate.

Oxford does not cover travel expenses, lodging, meals or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

15 HOME HEALTH CARE

***Preauthorization required**

Oxford covers care provided in your home by a home health agency certified or licensed by the appropriate state agency. The care must be provided by Physician-supervised health professionals pursuant to your Physician's written treatment plan and must be in lieu of hospitalization or confinement in a Skilled Nursing Facility. Home care includes (i) part-time or intermittent nursing care by or under the supervisions of a registered professional nurse (RN), (ii) part-time or intermittent services of a home health aide, (iii) physical, occupational, or speech therapy provided by the home health agency, and (iv) medical supplies, drugs and medications prescribed by an In-Network Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been covered during a hospitalization or confinement in a Skilled Nursing Facility.

Each visit up to four hours by a home health agency is considered one visit. Each visit of up to four hours by a home health aide is one visit. Refer to your Schedule of Benefits to determine if a limit applies to you.

Please note

Any rehabilitation services received under this benefit will not reduce the amount of services available under "Rehabilitation Services".

16 CHEMOTHERAPY

***Preauthorization required**

Oxford covers Chemotherapy in an outpatient facility or in a health care professional's office. When Chemotherapy is provided in the office, Preauthorization is not required. See *Hospital and Other Facility-Based Services*, under the heading *Hospital Services* for inpatient coverage.

17 SECOND OPINIONS

Oxford covers a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from an Out-of-Network Provider on an In-Network basis when your attending Physician provides a written Referral to an Out-of-Network Specialist.

Second Surgical Opinion

Oxford covers a second surgical opinion by a qualified Physician on the need for surgery.

Required Second Surgical Opinion

Oxford reserves the right to require a second opinion for any surgical procedure. At the time of Preauthorization, you may be advised that a second opinion will be required in order for the services to be covered. The second opinion must be given by a board certified Specialist who personally

examines you. If the first and second opinions do not agree, you may obtain a third opinion. There is no cost to you when Oxford requests a second opinion.

In the event that the first and second opinions differ, you may obtain a third opinion. The second and third surgical opinion consultants may not perform the surgery on you.

Second Opinions in Other Cases

There may be other instances when you will disagree with a Provider's recommended course of treatment. In such cases, you may request that Oxford designate another Provider to render a second opinion. If the first and second opinions do not agree, Oxford will designate another Provider to render a third opinion. After completion of the second opinion process, Oxford will Preauthorize Covered Services supported by a majority of the Providers reviewing your case.

18 CHIROPRACTIC SERVICES

Oxford will cover spinal subluxation and related services when performed by a doctor of chiropractic ("Chiropractor"). This includes assessment, manipulation and any modalities.

This benefit remains subject to Medically Necessity. Any Medically Necessary laboratory tests will be covered in accordance with the terms and conditions of this Supplement.

19 CLINICAL TRIALS FOR CANCER OR DISABLING OR LIFE THREATENING CHRONIC DISEASE

Oxford will cover the routine patient costs associated with a qualifying clinical trial for cancer or a disabling or life-threatening chronic disease.

- ▶ Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- ▶ Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as Oxford determines, a clinical trial meets the qualifying clinical trial criteria stated below.
- ▶ Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as Oxford determines, a clinical trial meets the qualifying clinical trial criteria stated below.
- ▶ Other diseases or disorders which are not life threatening for which, as Oxford determines, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the covered person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- ▶ Covered health services for which benefits are typically provided absent a clinical trial.
- ▶ Covered health services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of

the item or service, or the prevention of complications.

- ▶ Covered health services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- ▶ The Experimental or Investigational Service or item. The only exceptions to this are:
 - Certain *Category B* devices.
 - Certain promising interventions for patients with terminal illnesses.
 - Other items and services that meet specified criteria in accordance with Oxford’s medical and drug policies.
- ▶ Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- ▶ A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- ▶ Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is 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 life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular

disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- ▶ Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
- ▶ A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
- ▶ A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
- ▶ The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:

- Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
- Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- ▶ The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- ▶ The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- ▶ The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (*IRBs*) before participants are enrolled in the trial. Oxford may, at any time, request documentation about the trial.
- ▶ The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Please remember, the Covered Service must be Preauthorized.

20 HEARING AIDS

Oxford covers hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. Oxford covers a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years.

Bone anchored hearing aids are covered only if you have either of the following:

- ▶ Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- ▶ Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

If you meet the criteria for a bone anchored hearing aid, coverage is provided for one hearing aid per ear during the entire period of time that you are enrolled under this plan. Replacements and/or repairs for a bone anchored hearing aid are covered only for malfunctions.

21 DIALYSIS

Oxford covers dialysis treatments of an acute or chronic kidney ailment.

22 GENDER DYSPHORIA

**Preauthorization required for Gender Dysphoria treatment*

Oxford covers benefits for the treatment of Gender Dysphoria limited to the following services:

- ▶ Psychotherapy for Gender Dysphoria and associated comorbid psychiatric diagnoses are provided as described under Mental Health Services in this Supplement.

▶ Cross-sex hormone therapy:

- Cross-sex hormone therapy administered by a medical Provider (for example during an office visit) is provided under physician-administered pharmaceuticals in your Supplement.

- ▶ Puberty suppressing medication injected or implanted by a medical Provider in a clinical setting.

- ▶ Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.

- ▶ Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

Male to Female:

- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

Female to Male:

- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)

- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation

Requirements

The covered person must provide documentation of the following for breast surgery:

- ▶ A written psychological assessment from at least one qualified behavioral health Provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
 - Persistent, well-documented Gender Dysphoria.
 - Capacity to make a fully informed decision and to consent for treatment.
 - Must be 18 years or older.
 - If significant medical or mental health concerns are present, they must be reasonably well controlled.
- ▶ The Covered Person must provide documentation of the following for genital surgery:
 - Persistent, well-documented Gender Dysphoria.
 - Capacity to make a fully informed decision and to consent for treatment.
 - Must 18 years or older.
- ▶ A written psychological assessment from at least two qualified behavioral health Providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria.
 - Persistent, well-documented Gender Dysphoria.
 - Capacity to make a fully informed decision and to consent for treatment.
 - Must 18 years or older.

- If significant medical or mental health concerns are present, they must be reasonably well controlled.
- Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
- ▶ The treatment plan is based on identifiable external sources including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence-based professional society guidance.

23 CELLULAR AND GENE THERAPY

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility or in a physician's office.

Benefit for CAR-T therapy for malignancies are provided as described under the section on Transplants.

C HOSPITAL AND OTHER FACILITY-BASED SERVICES

Please remember, in order to receive coverage for any facility based Covered Service, the Covered Service must be Preauthorized.

1 HOSPITAL SERVICES

**Hospital admissions require Preauthorization.*

All Preauthorized admissions to In-Network Hospitals are covered on an In-Network basis; regardless of whether or not the admitting Provider is an In-Network Provider.

Inpatient Services

Coverage hospital inpatient services for Medically Necessary, acute-care includes: semi-private room and board, unlimited days, general nursing care and the following additional facilities, services and supplies: meals and special diets; use of operating room and related facilities; use of intensive care or cardiac care units and related services; x-ray services; laboratory and other diagnostic tests; drugs; medications; biologicals; anesthesia and oxygen services; short-term physical, speech and occupational therapy; radiation therapy; inhalation therapy; chemotherapy; whole blood and blood products; and the administration of whole blood and blood products.

Inpatient Stay for Lymph Node Dissection or Lumpectomy

Oxford will cover hospital inpatient services for Participants undergoing a lymph node dissection or lumpectomy. Coverage is available for the period of time determined to be Medically Necessary by you and your Physician.

Autologous Blood Banking Services

Autologous blood banking services are covered only when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, Oxford will cover storage fees for what Oxford determines to be a reasonable storage period that is Medically Necessary and appropriate for having the blood available when it is needed.

Routine harvesting and storage of Stem Cells from newborn cord blood is not covered.

Outpatient Services

Oxford covers the inpatient hospital services and supplies listed above that can be provided to you while being treated in the outpatient facility.

Please remember

Unless you are receiving preadmission testing, In-Network Hospitals are not In-Network Providers for laboratory procedures and tests.

Please note

Lab work and x-rays performed in a hospital on an outpatient basis do not require Preauthorization.

② AMBULATORY SURGERY CENTER

Coverage is available for covered surgical procedures performed at Ambulatory Surgical Centers. Oxford also covers the Covered Services and supplies provided by the center the day the surgery is performed.

③ SKILLED NURSING FACILITY

**This benefit requires Preauthorization and treatment plan.*

Oxford covers non-custodial services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. In addition to Preauthorization, an admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by your Provider and approved by Oxford. Oxford covers noncustodial care for the amount of days shown in the *Plan Highlights*.

④ HOSPICE

**This benefit requires*

Preauthorization for services rendered inpatient or in the home.

Hospice Care is available to Participants who have a prognosis of six months or less to live. Coverage consists of palliative care rather than curative treatment. Oxford covers a total of five visits for supportive care and guidance for the purpose of helping the Participant and the Participant's immediate family cope with the emotional and social issues related to the Participant's death. Hospice Care will be covered only when provided as part of a Hospice Care program certified by the appropriate state agency. Such certified programs may include Hospice Care delivered by: a hospital (inpatient or outpatient), Home Health Care Agency, Skilled Nursing Facility or a licensed Hospice facility.

Coverage is not provided for:

Funeral arrangements, pastoral, financial or legal counseling; homemaker, caretaker or respite care.

D EMERGENCIES

In order to obtain coverage for emergencies, you should follow the instructions below, regardless of whether or not you are in the Service Area at the time of the emergency. Emergencies include Covered Services provided by any health care Provider as outlined below:

Oxford defines an emergency as follows: a serious medical condition or symptom resulting from Injury, sickness or mental illness, or substance abuse disorders which: (a) arise suddenly; and (b) in the judgment of a reasonable person, requires immediate care and treatment, generally received

within 24 hours of onset, to avoid jeopardy to life or health.

With respect to a pregnant Participant who is having contractions, an emergency exists where: there is inadequate time to affect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the mother or the unborn child.

Emergencies include, but are not limited to, the following conditions:

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

Oxford reserves the right to review all appropriate medical records and make the final decision regarding the existence of an emergency. Regarding such retrospective reviews, Oxford will cover only those services and supplies that are Medically Necessary and are performed to treat or stabilize an emergency condition.

① HOSPITAL EMERGENCY ROOM VISITS

In the event of an emergency, seek immediate care at the nearest emergency room or call 911.

Emergency room care is not subject to Oxford's prior approval. However, only emergencies, as defined above, are covered in an

emergency room. If you would like assistance assessing the situation, you may call your In-Network Provider (if applicable). You can also call Oxford's Medical Management Coordinators or *Oxford-On-Call*. They are available 24 hours a day, 7 days a week. Your In-Network Provider or *Oxford-On-Call* will direct you to the emergency room of a hospital or other appropriate facility.

Follow-up care provided in a hospital emergency room is not covered.

② EMERGENCY HOSPITAL ADMISSIONS

In the event you are admitted to the hospital, you or someone on your behalf must notify Oxford at the emergency telephone number listed in the front of this Supplement within 48 hours of your admission, or as soon as is reasonably possible.

It is important to remember that only those conditions that meet all of the requirements contained in the definition of emergency will be covered as an emergency. Routine care received in an emergency room is not covered.

③ AMBULANCE SERVICES

**This benefit may require Preauthorization*

Ambulance services for life-threatening emergencies will be covered. Ambulance services for all other emergencies will be covered when Medically Necessary.

Oxford also covers pre-hospital emergency medical services. This means Oxford covers the prompt evaluation and treatment of an emergency in addition to non-air-borne transportation of the patient.

Inter-facility ambulance transfers will also be covered if they receive Preauthorization.

④ PAYMENTS RELATING TO EMERGENCY SERVICES RENDERED

The amount Oxford pays an Out-of-Network Provider for emergency services will be the greater of:

- ▶ the amount the Claims Administrator has negotiated with In-Network Providers for the emergency service received (and if more than one amount is negotiated, the median of the amounts);
- ▶ 100% of the Eligible Expense for Services provided by an Out-of-Network Provider (i.e., the amount the Claims Administrator would pay in the absence of any cost-sharing that would otherwise apply for services of Out-of-Network Providers); or
- ▶ the amount that would be paid under Medicare. The amounts described above exclude any Co-Payment or Coinsurance that applies to emergency services provided by an In-Network Provider.

You are responsible for any Deductible, Coinsurance or Co-Payment.

⑤ URGENT CARE

Oxford defines Urgent Care as medical care for a condition that needs immediate attention to minimize severity and prevent complications, but is not an emergency. Urgent Care is covered in or out of the Service Area.

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

Reimbursement and Co-Payments

When you receive Covered Services for an emergency or Urgent Care situation from an Out-of-Network Provider, outside of the Service Area, Oxford will limit reimbursement to the Usual, Customary and Reasonable charges for those expenses incurred up to the time the Participant is determined to be able to travel to an In-Network Provider. The Out-of-Network Reimbursement Amount is the amount charged or the amount Oxford determines to be the reasonable charge, whichever is less, for a particular Covered Service in the geographical area it is performed. Additionally, reimbursement is subject to all applicable Co-Payments as similar services provided by an In-Network Provider.

Ⓔ MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES

① MENTAL HEALTH CARE SERVICES

Inpatient Services

Oxford covers inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar hospital, medical, and surgical coverage provided under this Supplement. Coverage for inpatient services for mental health care is limited to facilities such as:

- ▶ A psychiatric center or inpatient facility;
- ▶ A state or local government run psychiatric inpatient facility;
- ▶ A part of a hospital providing inpatient mental health care services;

- ▶ A comprehensive psychiatric emergency program or other facility providing inpatient mental health care.

Oxford also covers inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to facilities and to residential treatment facilities that are licensed or certified under applicable law.

Outpatient Services

Oxford covers outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes facilities that have been issued an operating certificate pursuant to applicable law or are operated by the Office of Mental Health and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst or a professional corporation or a university faculty practice corporation thereof.

Limitations/Terms of Coverage

Oxford does not cover:

- ▶ Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the

individual's mental health needs;

- ▶ Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth; or
- ▶ Services solely because they are ordered by a court.

② SUBSTANCE USE SERVICES

Inpatient Services

Oxford covers inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency. This includes coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to those facilities that are licensed or certified by a state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

Oxford also covers inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency received at facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is to those facilities that are licensed or certified by a state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

Outpatient Services

Oxford covers outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and

dependency, including but not limited to partial hospitalization program service, intensive outpatient program service, and methadone treatment. Such coverage is limited to facilities to those that are licensed or certified by a state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation.

Oxford also covers up to 20 outpatient visits per calendar year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member:

- ▶ identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and
- ▶ is covered under the same plan that covers the person receiving, or in need of, treatment for substance use, and/or dependency. Plan payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

Exclusions And Limitations

Unless coverage is specifically provided under this Supplement or provided under a rider or attachment to this Supplement, the following services and benefits are not covered by Oxford.

- 1 Aviation. Oxford does not cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.
- 2 Services which are not Medically Necessary. If there is a dispute between a Provider and Oxford about the Medical Necessity of a service or supply, you or your Provider may appeal Oxford's decision. Any disputed service or supply will not be covered during the appeal process.
- 3 Acupuncture therapy.
- 4 An adopted newly born infant's initial hospital stay if the natural parent has coverage available for the infant's care.
- 5 Blood, blood plasma and blood derivatives other than those described as Covered Services. Synthetic blood, apheresis or plasmapheresis, the collection and storage of blood, and the cost of securing the services of blood donors are not covered.
- 6 Birth control pills, implantable or injectable contraceptive drugs, condoms, foams or devices, IUDs, diaphragms, contraceptive jellies and ointments, even if they are being prescribed or recommended for a medical condition other than birth control.
- 7 To the extent allowed by law, Oxford does not cover care or treatment provided in an Out-of-Network hospital that is owned or operated by any federal, state or other governmental entity.
- 8 Care for conditions that by federal, state or local law must be treated in a public facility including, but not limited to, commitments for mental illness. Additionally, to the extent allowed by law, Oxford does not cover care or treatment provided in an Out-of-Network hospital that is owned or operated by any federal, state or other governmental entity.
- 9 Comfort or convenience items including, but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. Oxford also does not cover the purchase or rental of household fixtures or equipment including, but not limited to: escalators; elevators; swimming pools; exercise cycles; treadmills, weight training or muscle strengthening equipment; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.
- 10 Cosmetic, reconstructive or plastic surgery that is done for a condition that does not meet the specific criteria stated in "Reconstructive and Corrective Surgery," including but not limited to: cosmetic surgery, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body including but not limited to: surgery for sagging or extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; rhinoplasty and rhinoplasty done in conjunction with covered nasal or covered sinus surgery. Complications of such surgeries are covered only if they are Medically Necessary and are otherwise covered. Remedial work is not covered.
- 11 Court ordered services or services that have been ordered as a condition of probation or parole. However, these services may be covered if Oxford agrees that the services are Medically Necessary, are otherwise covered, the Participant has not exhausted their benefit for the contract/calendar year, and the treatment is provided in accordance with our policies and procedures.
- 12 Convalescent and Custodial Care. Oxford does not cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.
- 13 Conversion Therapy. Oxford does not cover conversion therapy. Conversion therapy

is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

14 **Cosmetic Services.** Cosmetic, Prescription Drugs, or reconstructive or plastic surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect. Oxford also covers services in connection with reconstructive surgery following a mastectomy, as

provided elsewhere in this Supplement. Cosmetic surgery does not include surgery determined to be Medically Necessary.

15 **Dental Services.** Oxford does not cover dental services for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment as specifically stated in the Outpatient and Professional Services section of this Supplement.

16 The following are not covered as diabetic services or supplies: services or supplies that are not both Medically Necessary and prescribed by the Participant's Physician or qualified health professional; membership in health clubs, diet plans or clubs even if recommended by a Physician or any other Provider for purpose of losing weight; any counseling or courses in diabetes management other than as described as covered under this Supplement; stays at special facilities or spas for the purpose of diabetes education/management; special foods, diet aids and supplements related to dieting.

17 **Durable Medical Equipment** (other than as specifically covered under this Supplement). Oxford also does not cover: TENS units (except as covered under Durable Medical Equipment); blood pressure monitoring devices; car seats; arch supports; cervical collars; corrective shoes; false teeth; tilt tables; electronic

communication devices; in-flight oxygen for non-emergency travel; special supplies or equipment; or special appliances.

18 **Experimental or Investigational Treatment.** Oxford does not cover any health care service, procedure, treatment, device, or prescription drug that is experimental or investigational. However, Oxford will cover experimental or investigational treatments, including treatment for your rare disease or patient costs for your participation in a clinical trial, when Oxford's denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials Oxford will not cover the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under the Supplement for non-investigational treatments.

19 **Improper use of an emergency room or emergency admissions.** Routine care and treatment for conditions that Oxford determines were not emergencies, when received in an emergency room, are not covered.

20 **Infertility treatments and supplies** (except as otherwise covered under this Supplement), even if the treatment or supply is for a purpose other than the correction of infertility. The following services and supplies are not covered: cost for an ovum donor or donor sperm, sperm storage

costs, chromosomal analyses, testicular biopsy, elective abdominal surgeries related to lysis of adhesions or asymptomatic varicoceles, radiographic imaging to determine tubal patency; blood analyses related to immunological diagnosis of infertility, cryopreservation and storage of embryos (unless the Participant has not yet reached her lifetime limit of four egg retrievals), in-vitro services for women who have undergone tubal ligation, any infertility services if the male has undergone a vasectomy the following services related to a Gestational Carrier or Surrogate (i) fees for the use of a Gestational Carrier or Surrogate, (ii) pregnancy services for a Gestational Carrier or Surrogate who is not a covered person. Oxford also does not cover services to reverse voluntary sterilization. Treatment of an underlying medical condition will not be denied (if the treatment is otherwise covered under the Supplement) solely because the medical condition results in infertility.

- 21 Learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of: learning disabilities or minimal brain dysfunction; mental retardation; developmental and learning disorders or behavioral problems. Oxford also does not cover behavioral training, visual perceptual or visual motor training related to learning disabilities or cognitive rehabilitation. Behavioral and learning disorders related to

congenital abnormalities such as Down's Syndrome are not covered.

- 22 Services and treatment provided in a government facility, i.e., military services-related injuries.
- 23 No-fault automobile insurance. Any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy.
- 24 Non-eligible institutions. Any services or supplies furnished by a non-eligible institution, which is defined as other than a hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.
- 25 Non-medical services and long-term rehabilitation services for physical therapy or the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility, except as specifically covered under this Supplement.
- 26 No-show charges. If a Provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.
- 27 Occupational conditions, ailments, or injuries arising out of and in the course of employment. Such conditions, ailments or injuries are not covered if they are subject

to coverage, in whole or in part, under any workers' compensation, occupational disease or similar law. This applies even if the Participant's rights have been waived or qualified.

- 28 Outpatient prescription drugs, unless coverage has been purchased by the Plan. For the outpatient prescription drug benefits available to you through Express Scripts, see the Motion Picture Industry Health Plan SPD for Active Participants.
- 29 Self-injectable medications. This exclusion does not apply to drugs for the treatment of diabetes and medications which, due to their characteristics (as determined by Oxford), must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional in an outpatient setting.
- 30 Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in a medical emergency and consumed in the Physician's office.
- 31 Over-the-counter drugs and treatments.
- 32 Growth hormone therapy.
- 33 A pharmaceutical product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered pharmaceutical product. For the purpose of this exclusion a "biosimilar" is a biological pharmaceutical product approved based

on showing that it is highly similar to a reference product (a biological pharmaceutical product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

- 34 Certain pharmaceutical products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by Oxford. Such determinations may be made up to six times during a calendar year.
- 35 New U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a covered health service by a Physician and/or new dosage forms until the date they are reviewed.
- 36 Private or special duty nursing.
- 37 Rehabilitation services or physical therapy on a long-term basis. Speech or occupational therapy to correct a condition that is not the result of a disease, injury or a congenital defect for which surgery has been performed.
- 38 Routine foot care including nail trimming, corn and callous removal, cleaning, soaking or any other hygienic maintenance or care.
- 39 Services for which the day or visit limit identified in the *Plan Highlights* has been met.
- 40 Services performed in

connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Associate.

- 41 Services, solely because such services are ordered by a court.
- 42 Sex, marital or religious counseling, including sex therapy and treatment of sexual dysfunction.
- 43 Special foods and diets, supplements, vitamins and enteral feedings, except as what is otherwise outlined in this Supplement. When coverage of special foods, diets and enteral feedings are available, it is subject to periodic review for Medical Necessity. Infant formulas are not covered.
- 44 Special medical reports not directly related to treatment. Appearances in court or at a hearing.
- 45 Temporomandibular joint syndrome. Dental procedures and appliances for the treatment of temporomandibular joint syndrome or craniomandibular pain syndrome. Surgical and nonsurgical medical procedures are covered if Preauthorized and approved by Oxford's Medical Director.
- 46 Third party requests for physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state or federal government; obtaining insurance coverage; foreign travel; school admissions or attendance including examinations

required for participation in athletic activities. Court ordered psychological or behavioral evaluations or counseling related to marital disputes, divorce proceedings, or child custody proceedings are not covered.

- 47 Transplant services required by a Participant when the Participant serves as an organ donor are not covered unless the recipient is a Participant. The medical expenses of a non-Participant acting as a donor for a Participant are not covered if the non-Participant's expenses will be covered under another health plan or program. Donor fees in connection with organ transplant surgery are excluded. Oxford does not cover travel expenses, lodging, meals or other accommodations for donors or guests. Transplants performed in facilities other than those designated by Oxford for the transplant procedure are not covered.
- 48 Treatment provided in connection with services for individuals who are presently incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the office of children and family services.
- 49 Coverage outside of the United States. No coverage is available outside of the United States if the Participant traveled out-of-the-country to obtain medical treatment, drugs or supplies. Additionally, Oxford will not cover any treatment, drugs or supplies that are unavailable or illegal in the United States. When a Participant is traveling

for other purposes, only emergencies and Urgent Care will be covered outside of the United States (with the exception of Canada, Mexico and U.S. possessions)

- 50 Unnecessary Care. In general, Oxford will not cover any health care service that in Oxford's sole judgment, determines is not Medically Necessary. If an external appeal agent certified by the State overturns Oxford's denial, however, Oxford shall cover the procedure, treatment, service, pharmaceutical product, or durable medical equipment for which coverage has been denied, to the extent that such procedure, treatment, service, pharmaceutical product, or durable medical equipment is otherwise covered under the terms of this Supplement.
- 51 Any charges by an Out-of-Network Provider for Covered Services that are in excess of Oxford's Fee Schedule are excluded from coverage and are the Participant's responsibility.
- 52 Eyeglasses and examination for the prescription of fitting thereof. For the vision benefits available to you, see the Motion Picture Industry Health Plan SPD for Active Participants.
- 53 Wigs, or any other appliance or procedure related to hair loss regardless of the disease or injury causing the hair loss (except following chemotherapy).
- 54 Weight Control. All services, supplies, programs and surgical procedures for the purpose of weight control.
- 55 Any service, supply or

treatment not specifically listed in this Supplement as a Covered Service, supply or treatment. Any supply or treatment for which the Participant has no legal obligation to reimburse the Provider. Any supply or treatment provided by a Participant of the Participant's family (mother, step-mother, father, step-father, sister, step-sister, brother, step-brother, any "in-law," aunt, uncle, niece, nephew or cousin).

- 56 Services Provided by a Family Member. Oxford does not cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of you or your spouse.
- 57 Medicare or Other Government Program. Oxford does not cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When you are eligible for Medicare Oxford will reduce your benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if you fail to enroll in Medicare or you do not pay your Medicare Premium. Benefits for Covered Services will not be reduced if the Plan is required by federal law to pay first or if you are not eligible for premium-free Medicare Part A.
- 58 Gender Dysphoria. Cosmetic Procedures, including the following:
 - Abdominoplasty.
 - Blepharoplasty.

- Breast enlargement, including augmentation mammoplasty and breast implants.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

AUTISM SPECTRUM DISORDERS, EXCEPT AS SPECIFICALLY PROVIDED UNDER THIS SUPPLEMENT.

- 1 Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- 2 Any treatments or other specialized services designed

for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore are considered Experimental or Investigational.

- 3 Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- 4 Relational problems as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- 5 Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
- 6 Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder.
- 7 Treatments for the primary diagnosis of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by Oxford.

8 Services or supplies for the diagnosis or treatment of mental illness that, in Oxford's reasonable judgment, are not Medically Necessary or are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore are considered Experimental or Investigational.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with Oxford's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate in terms of type frequency, extent, site and duration of treatment, and considered ineffective for the patient's mental illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

Oxford may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

MENTAL HEALTH SERVICES

1 Services performed in

connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

- 2 Mental Health Services as treatment for a primary diagnosis of sexual dysfunction disorders.
- 3 Treatments for the primary diagnoses of learning disabilities.
- 4 Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
- 5 Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
- 6 Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- 7 Mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- 8 Relational problems as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- 9 Services or supplies for the diagnosis or treatment of Mental Illness that, in Oxford's reasonable judgment, are not Medically Necessary or are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore are considered Experimental or Investigational.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with Oxford's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate in terms of type frequency, extent, site and duration of treatment, and considered ineffective for the patient's mental illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

Oxford may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

SUBSTANCE USE DISORDERS

- 1 Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- 2 Methadone treatment as

maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.

- 3 Substance Use Disorder Services for the treatment of caffeine use.
- 4 Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
- 5 Services or supplies for the diagnosis or treatment of substance use disorders that, in Oxford's reasonable judgment, are not Medically Necessary or are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore are considered Experimental or Investigational.
 - Not consistent with Oxford's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate and considered ineffective for the patient's mental illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

Oxford may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

Participant Rights And Responsibilities

WHAT ARE MY RIGHTS AS A PARTICIPANT?

As a Participant you have the following rights:

- 1 The right to obtain complete and current information concerning a diagnosis, treatment and prognosis from any In-Network Provider in terms that you or your authorized representative can readily understand. You have the right to be given the name, professional status and function of any personnel delivering Covered Services to you.

You have the right to receive all information from an In-Network Provider necessary for you to give your informed consent prior to the start of any procedure or treatment.

You also have the right to refuse treatment to the extent permitted by law. Oxford and your PCP will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended treatment and Oxford and your In-Network Provider believe no professionally acceptable alternative exists, Oxford will not be responsible for the cost of further treatment for that condition. You will be notified accordingly.

If a Participant is not capable of understanding any of this information, an explanation will be provided to his or her guardian, designee or a family Participant.

- 2 The right to be provided

with information about Oxford's services, policies, procedures, grievance and appeal procedures and Oxford's In-Network Providers that accurately provides relevant information in a manner that is easily understood.

- 3 The right to quality health care services, provided in a professional manner that respects your dignity and protects your privacy. You also have the right to participate in decision-making regarding your health care.

- 4 The right to privacy and confidentiality of your health records, except as otherwise provided by law or contract. You have the right to all information contained in your medical records unless access is specifically restricted by the attending physician for medical reasons.

- 5 The right to initiate disenrollment from Oxford.

- 6 The right to file a formal grievance or appeal if complaints or concerns arise about Oxford's medical or administrative services or policies.

- 7 The right, when Medically Necessary, to emergency care without unnecessary delay.

- 8 The right to be advised if any of the In-Network Providers participating in your care propose to engage in or perform human experimentation or research affecting your care

or treatment. You or a legally responsible party on your behalf may, at any time, refuse to participate in or to continue in any experimentation or research program to which you have previously given informed consent.

- 9 The right to sign-language interpreter services in accordance with applicable laws and regulations, when such services are necessary to enable you as a person with special communication needs to communicate effectively with your Provider.

WHAT ARE MY RESPONSIBILITIES?

Your Responsibilities Include:

- 1 To participate in Oxford with the intent of following the policies and procedures as outlined in this Supplement.
- 2 To take an active role in your health care through maintaining good relations with your Provider and following prescribed treatments and guidelines.
- 3 To provide, to the extent possible, information that professional staff need in order to care for you as a Participant.
- 4 To use the emergency room only as described in this Supplement.
- 5 To notify the proper Oxford representative of any change in name, address or any other important information.

Claims Procedures

WHAT THIS SECTION INCLUDES:

- ▶ How In-Network Provider and Out-of-Network Provider claims work; and
- ▶ What to do if your claim is denied, in whole or in part.

IN-NETWORK PROVIDER BENEFITS

In general, if you receive Covered Services from an In-Network Provider, Oxford will pay the Physician or facility directly. If an In-Network Provider bills you for any Covered Service other than your Co-Payment or Coinsurance, please contact the Provider or call the customer service phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the annual deductible and paying any Co-Payment or Coinsurance owed to an In-Network Provider at the time of service, or when you receive a bill from the Provider.

If you receive Covered Services from an In-Network Provider but not in accordance with the terms and conditions of this Supplement, coverage will be provided as described in this Supplement. When you see an In-Network Provider under these circumstances, the Covered Services will be treated as if they were delivered by an Out-of-Network Provider, and you must file a claim as described below.

OUT-OF-NETWORK PROVIDER BENEFITS

If you receive a bill for Covered Services from an Out-of-Network Provider, you (or the Provider if they prefer) must send the bill to Oxford for processing. To make sure

the claim is processed promptly and accurately, a completed claim form must be attached and mailed to Oxford at the address on the back of your ID card.

HOW TO SUBMIT A CLAIM

You can obtain a claim form by visiting www.oxhp.com, calling the toll-free customer service number on your ID card or contacting your Oxford's Administrator. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- ▶ your name and address;
- ▶ the patient's name, age and relationship to the Participant;
- ▶ the number as shown on your ID card;
- ▶ the name, address and tax identification number of the Provider of the service(s);
- ▶ a diagnosis from the Physician;
- ▶ the date of service;
- ▶ an itemized bill from the Provider that includes:
 - the Current Procedural Terminology (CPT) codes;
 - a description of, and the charge for, each service;
 - the date the sickness or injury began; and
 - a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with Oxford at the address on your ID card.

PAYMENT OF BENEFITS

When you assign your Benefits under the Plan to an Out-of-Network Provider with Oxford's consent, and the Out-of-Network Provider submits a claim for payment, you and the Out-of-Network Provider represent and warrant that the Covered health services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the Out-of-Network Provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the Provider, Oxford may in its discretion make payment of the benefits directly to the Provider for your convenience, but will treat you, rather than the Provider, as the beneficiary of your claim. If Benefits are assigned or payment to an Out-of-Network Provider is made, the Plan reserves the right

to offset Benefits to be paid to the Provider by any amounts that the Provider owes the Plan pursuant to Refund of Overpayments in Section 9 Coordination of Benefits.

Oxford will pay Benefits to you unless:

- ▶ The Provider submits a claim form to Oxford that you have provided signed authorization to assign Benefits directly to that Provider.
- ▶ You make a written request for the Out-of-Network Provider to be paid directly at the time you submit your claim.

Oxford will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your Provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that Oxford in its discretion determines to be adequate.

LIMITATIONS

(Timeframe for Filing Claims)

All requests for reimbursement must be made within 120 days of the date Covered Services were rendered. Failure to request reimbursement within the required time will not invalidate or reduce any claim if it was not reasonably possible to provide such proof within the 120-day period. However, such request must be made as soon as reasonably possible thereafter. Under no circumstances will Oxford or the Plan be liable for a claim that is submitted more than six months after the date services were rendered, unless you are legally incapacitated and unable to submit the request. All reimbursements

to Out-of-Network Providers are subject to an Out-of-Network Reimbursement Amount unless you were referred to an Out-of-Network Provider by your PCP or Oxford.

IF YOU RECEIVE A BILL FROM AN IN-NETWORK PROVIDER

The cost of Covered Services provided by In-Network Providers in accordance with the terms of this Supplement will be billed directly to Oxford. No claim forms are necessary.

If you should receive a bill from an In-Network Provider for Covered Services, please contact Oxford's customer service department immediately.

Claim Information

Please allow up to 30 business days for the processing of In-Network claims. Claims for Out-of-Network Covered Services will be paid within 60 business days after Oxford receives proof of the claim.

If necessary, Oxford's Claims Department will contact you for more information regarding your claim in order to speed up the processing. If you would like to inquire about the status of a claim, call the "Claims" telephone number list in the front of this Supplement. Please have the date of service and your ID number ready.

EXPLANATION OF BENEFITS (EOB)

You may request that Oxford send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like copies of the EOBs, you may call the toll-free Oxford customer service

number on your ID card to request them. You can also view and print all of your EOBs online www.oxhp.com.

LIMITATION OF ACTION

You cannot bring any legal action against the Plan Administrator or Oxford for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the Plan Administrator or Oxford you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan Administrator or Oxford.

CLAIM DENIALS AND APPEALS

If Your Claim is Denied

If a claim for benefits is denied in part or in whole, you may call Oxford at the number on your ID card before requesting a formal appeal. If Oxford cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- ▶ the patient's name and ID number as shown on the ID card;
- ▶ the Provider's name;
- ▶ the date of medical service;
- ▶ the reason you disagree with the denial; and

- ▶ any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

Oxford

P.O. Box 30432
Salt Lake City, Utah 84130-0432

For Urgent Care requests for benefits that have been denied, you or your Provider can call Oxford at the toll-free number on your ID card to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- ▶ urgent care request for benefits;
- ▶ pre-service request for benefits;
- ▶ post-service claim; or
- ▶ concurrent claim.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call Oxford at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

Review of an Appeal

Oxford will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- ▶ an appropriate individual(s) who did not make the initial benefit determination; and
- ▶ a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if Oxford upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

You are offered two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Plan's Benefits/Appeals Committee within 60 days from receipt of the first level appeal determination.

Note

Upon written request, any Covered Persons may examine their claim and/or appeals file(s) free of charge. Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. The Plan will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Timing of Appeals

Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

▶ **Urgent Care**

Request for Benefits

A request for benefits provided in connection with Urgent Care services, as defined in Section 12, *Glossary*;

▶ **Pre-Service**

Request for Benefits

A request for benefits which the Plan must approve or in which you must notify Oxford before non-Urgent Care is provided; and

▶ **Post-Service Claims**

A claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables on page 36 describe the time frames which you and Oxford are required to follow.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. Oxford will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for benefits and decided according to the timeframes described above. If an on-going

URGENT CARE REQUEST FOR BENEFITS*

TYPE OF REQUEST FOR BENEFITS OR APPEAL	TIMING
If your request for benefits is incomplete, Oxford must notify you within:	24 hours
You must then provide completed request for benefits information to Oxford within:	48 hours after receiving notice of additional information required
Oxford must notify you of the benefit determination within:	72 hours
If Oxford denies your request for benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
Oxford must notify you of the appeal decision within:	72 hours after receiving the appeal

Please see the SPD for information about further appeals to the Motion Picture Industry Health Plan Benefits/Appeals Committee.

*You do not need to submit Urgent Care appeals in writing. You should call Oxford as soon as possible to appeal an Urgent Care request for benefits.

PRE-SERVICE REQUEST FOR BENEFITS*

TYPE OF REQUEST FOR BENEFITS OR APPEAL	TIMING
If your request for benefits is filed improperly, Oxford must notify you within:	5 days
If your request for benefits is incomplete, Oxford must notify you within:	15 days
You must then provide completed request for benefits information to Oxford within:	45 days
Oxford must notify you of the benefit determination, if the initial request for benefits is complete, within:	15 days
Oxford must notify you of the benefit determination, after receiving the completed request for benefits (if the initial request for benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
Oxford must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
Oxford must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

Please see the SPD for information about further appeals to the Motion Picture Industry Health Plan Benefits/Appeals Committee.

*Oxford may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

POST-SERVICE CLAIMS

TYPE OF REQUEST FOR BENEFITS OR APPEAL	TIMING
If your claim is incomplete, Oxford must notify you within:	30 days
You must then provide completed claim information to Oxford within:	45 days
Oxford must notify you of the benefit determination, if the initial claim is complete, within:	30 days
Oxford must notify you of the benefit determination, after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
Oxford must notify you of the first level appeal decision within:	30 days after receiving the first level appeal

Please see the SPD for information about further appeals to the Motion Picture Industry Health Plan Benefits/Appeals Committee.

course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against the Plan or Oxford to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the Plan or Oxford, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the Plan or Oxford.

You cannot bring any legal action against the Plan or Oxford for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the Plan or Oxford you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan or Oxford.

Employee Retirement Income Security Act (ERISA) Rights

After all levels of Appeals have been completed, the Participant may have the right to file a civil action under 502(a) of the Employee Retirement Income Security Act.

Coordination Of Benefits

WHAT THIS

SECTION INCLUDES:

- ▶ How your benefits under this plan coordinate with other medical plans;
- ▶ How coverage is affected if you become eligible for Medicare; and
- ▶ Procedures in the event Oxford overpays benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- ▶ another employer sponsored health benefits plan;
- ▶ a medical component of a group long-term care plan, such as skilled nursing care;
- ▶ no-fault or traditional “fault” type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- ▶ medical payment benefits under any premises liability or other types of liability coverage; or
- ▶ Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine

its benefits based on the benefits paid by the primary plan. How much Oxford will reimburse you, if anything, will also depend in part on the allowable expense. The term, “allowable expense,” is further explained below.

DETERMINING WHICH PLAN IS PRIMARY

Order of Benefit

Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- ▶ Oxford will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- ▶ when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- ▶ a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- ▶ if you are receiving COBRA continuation coverage under another employer plan, Oxford will pay benefits first;
- ▶ your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:

- the parents are married or living together whether or not they have ever been married and not legally separated; or
- a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;

- ▶ if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:

- the parent with custody of the child; then
- the spouse of the parent with custody of the child; then
- the parent not having custody of the child; then
- the spouse of the parent not having custody of the child;
- ▶ plans for active employees pay before plans covering laid-off or retired employees;
- ▶ the plan that has covered the individual claimant the longest will pay first; and
- ▶ finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, Oxford will not pay more than it would have paid had it been the primary plan.

The following examples illustrate how Oxford determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

- 1 Let's say you and your spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under Oxford, and as a Dependent under your spouse's plan, Oxford will pay benefits for the Physician's office visit first.
- 2 Again, let's say you and your spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. Oxford will look at your birthday and your spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your spouse's plan will pay first.

WHEN OXFORD IS SECONDARY

If Oxford is secondary it determines the amount it will pay for a Covered Service by following the steps below.

- ▶ Oxford determines the amount it would have paid based on the allowable expense.
- ▶ If Oxford would have paid the same amount or less than the primary plan paid, Oxford pays no benefits.
- ▶ If Oxford would have paid more than the primary plan paid, Oxford will pay the difference.

You will be responsible for any Co-Payment, Coinsurance or Deductible payments as part of the COB payment. The maximum

combined payment you can receive from all plans may be less than 100% of the allowable expense.

DETERMINING THE ALLOWABLE EXPENSE IF OXFORD IS SECONDARY

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the Provider is an In-Network Provider for both the primary plan and Oxford, the allowable expense is the primary plan's network rate.

When the Provider is an In-Network Provider for the primary plan and Out-of-Network Provider for Oxford, the allowable expense is the primary plan's network rate.

When the Provider is an Out-of-Network Provider for the primary plan and an In-Network Provider for Oxford, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the Provider is an Out-of-Network Provider for both the primary plan and Oxford, the allowable expense is the greater of the two plans' reasonable and customary charges. If Oxford is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When This Plan is Secondary to Medicare".

WHEN A COVERED PERSON QUALIFIES FOR MEDICARE

Determining Which Plan is Primary

As permitted by law, Oxford will pay benefits second to Medicare when you become eligible for Medicare, even if you don't elect

it. There are, however, Medicare-eligible individuals for whom Oxford pays benefits first and Medicare pays benefits second.

There are, however, Medicare-eligible individuals for whom Oxford pays benefits first and Medicare pays benefits second:

- ▶ employees with active current employment status age 65 or older and their Spouses age 65 or older; and
- ▶ individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When Oxford is Secondary to Medicare

If Oxford is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the Provider accepts reimbursement directly from Medicare. If the Provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such Providers a percentage of its approved charge – often 80%.

If the Provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a Provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with plan benefits, will not exceed 100% of the allowable expense.

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 Oxford and other plans. Oxford may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under Oxford and other plans covering the person claiming benefits.

Oxford does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Oxford any facts needed to apply those rules and determine benefits payable. If you do not provide Oxford the information needed to apply these rules and determine the benefits payable, your claim for benefits will be denied.

OVERPAYMENT AND UNDERPAYMENT OF BENEFITS

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that Oxford should have paid. If this occurs, Oxford may pay the other plan the amount owed.

If Oxford pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan may recover the amount in the form of salary, wages, or benefits payable under any plan-sponsored benefit plans. The Plan also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If Oxford overpays a health care Provider, the Plan reserves the right to recover the excess amount, from the Provider pursuant to *Refund of Overpayments*, below.

REFUND OF OVERPAYMENTS

If Oxford pays for benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- ▶ The Plan's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- ▶ all or some of the payment the Plan made exceeded the benefits under the Plan;
- ▶ all or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the

Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future benefits that are payable in connection with services provided to persons under other plans for which Oxford makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Subrogation and Reimbursement

WHAT THIS SECTION INCLUDES:

- ▶ How your benefits are impacted if you suffer a sickness or injury caused by a third party.

The Plan has a right to subrogation and reimbursement, as defined below. References to “you” or “your” in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid benefits on your behalf for a sickness or injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the sickness or injury for which any third party is considered responsible.

Subrogation – Example

Suppose you are injured in a car accident that is not your fault, and you receive benefits from Oxford to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver’s insurance carrier to recover the cost of those benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds

to fully return to the Plan 100% of any benefits you receive for that sickness or injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example

Suppose you are injured in a boating accident that is not your fault, and you receive benefits through Oxford as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any benefits you received to treat your injuries.

THE FOLLOWING PERSONS AND ENTITIES ARE CONSIDERED THIRD PARTIES:

- ▶ A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages.
- ▶ Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages.
- ▶ The Plan Sponsor in a workers’ compensation case or other matter alleging liability.
- ▶ Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment

coverage (auto, homeowners or otherwise), workers’ compensation coverage, other insurance carriers or third party administrators.

- ▶ Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a sickness or injury you allege or could have alleged were the responsibility of any third party.
- ▶ Any person or entity that is liable for payment to you on any equitable or legal liability theory.

YOU AGREE AS FOLLOWS:

- ▶ You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
 - Providing any relevant information requested by the Plan.
 - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Making court appearances.

- Obtaining the Plan’s consent or its agents’ consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys’ fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- ▶ The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan’s first priority right to payment is superior to any and all claims, debts or liens asserted by any medical Providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- ▶ The Plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries

paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys’ fees, shall be deducted from the Plan’s recovery without the Plan’s express written consent. No so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall defeat this right.

- ▶ Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No “Collateral Source” rule, any “Made-Whole Doctrine” or “Make-Whole Doctrine,” claim of unjust enrichment, nor any other equitable limitation shall limit the Plan’s subrogation and reimbursement rights.
- ▶ Benefits paid by the Plan may also be considered to be benefits advanced.
- ▶ If you receive any payment from any party as a result of sickness

or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative’s trust account.

- ▶ By participating in and accepting benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- ▶ The Plan’s rights to recovery will not be reduced due to your own negligence.
- ▶ By participating in and accepting benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, personal injury protection benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the benefits the Plan has paid for the sickness or injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan’s right to assert, pursue and recover on any such claim, whether or not you choose to pursue the

claim, and you agree to this assignment voluntarily.

- ▶ The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the sickness or injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- ▶ You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- ▶ The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- ▶ In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death, the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you

or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- ▶ No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- ▶ The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a sickness or injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- ▶ If any third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- ▶ In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to you, your dependents or the participant, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused

by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- ▶ The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to:
 - 1 construe and enforce the terms of the Plan's subrogation and reimbursement rights and
 - 2 make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- ▶ made in error;
- ▶ due to a mistake in fact;
- ▶ advanced during the time period of meeting the calendar year Deductible; or
- ▶ advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a benefit

for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- ▶ require that the overpayment be returned when requested, or
- ▶ reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover benefits it has advanced by:

- ▶ submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- ▶ conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Other Important Information

YOUR RELATIONSHIP WITH OXFORD AND THE PLAN ADMINISTRATOR

In order to make choices about your health care coverage and treatment, the Motion Picture Industry Health Plan (“Plan” and “Plan Administrator”) believes that it is important for you to understand how Oxford interacts with the Plan Administrator and how it may affect you. Oxford helps administer the Plan in which you are enrolled. Oxford does not provide medical services or make treatment decisions. This means:

- ▶ Your Plan Administrator and Oxford do not decide what care you need or will receive. You and your Physician make those decisions;
- ▶ Oxford communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Services, which are more fully described in this Supplement); and
- ▶ the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Plan Administrator and Oxford may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Plan Administrator and Oxford will use individually identifiable information about you as permitted or required by

law, including in operations and in research. The Plan Administrator and Oxford will use de-identified data for commercial purposes including research.

RELATIONSHIP WITH PROVIDERS

The relationships among the Plan Administrator, Oxford and In-Network Providers are solely contractual relationships between independent contractors. In-Network Providers are not the Plan Administrator’s agents or employees, nor are they agents or employees of Oxford. The Plan Administrator and any of its employees are not agents or employees of In-Network Providers, nor is Oxford and any of its employees agents or employees of In-Network Providers.

The Plan Administrator and Oxford do not provide health care services or supplies, nor do they practice medicine. Instead, the Plan and Oxford arrange for health care Providers to participate in a network and pay benefits. In-Network Providers are independent practitioners who run their own offices and facilities. Oxford’s credentialing process confirms public information about the Providers’ licenses and other credentials, but does not assure the quality of the services provided. They are not the Plan Administrator’s employees nor are they employees of Oxford. The Plan Administrator and Oxford do not have any other relationship with In-Network Providers such as principal-agent or joint venture.

The Plan Administrator and Oxford are not liable for any act or omission of any Provider.

Oxford is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

The Plan Administrator is solely responsible for:

- ▶ enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- ▶ the timely payment of benefits; and
- ▶ notifying you of the termination or modifications to the Plan.

YOUR RELATIONSHIP WITH PROVIDERS

The relationship between you and any Provider is that of Provider and patient. Your Provider is solely responsible for the quality of the services provided to you. You:

- ▶ are responsible for choosing your own Provider;
- ▶ are responsible for paying, directly to your Provider, any amount identified as a member responsibility, including Co-Payments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- ▶ are responsible for paying, directly to your Provider, the cost of any non-Covered Service;
- ▶ must decide if any Provider

treating you is right for you (this includes In-Network Providers you choose and Providers to whom you have been referred); and

- ▶ must decide with your Provider what care you should receive.

INTERPRETATION OF BENEFITS

The Plan Administrator and Oxford have the sole and exclusive discretion to:

- ▶ interpret benefits under the Plan;
- ▶ interpret the other terms, conditions, limitations and exclusions of the Plan, including this Supplement and any Riders and/or Amendments; and
- ▶ make factual determinations related to the Plan and its benefits.

The Plan Administrator and Oxford may delegate this discretionary authority to other persons or entities that provide services in regard to administration.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan Administrator may, in its discretion, offer benefits for services that would otherwise not be Covered Services. The fact that the Plan Administrator does so in any particular case shall not in any way be deemed to require the Plan Administrator to do so in other similar cases.

INFORMATION AND RECORDS

Your medical records are confidential documents. The Plan and Oxford may use your individually identifiable health

information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. The Plan and Oxford may request additional information from you to decide your claim for benefits. The Plan and Oxford will keep this information confidential. The Plan and Oxford may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Plan and Oxford with all information or copies of records relating to the services provided to you. The Plan and Oxford have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. The Plan and Oxford agree that such information and records will be considered confidential.

The Plan and Oxford have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Plan is required to do by law or regulation. During and after the term of the Plan, The Plan and Oxford and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing

statements the Plan recommends that you contact your health care Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from Oxford, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, the Plan and Oxford will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Oxford's designees have the same rights to this information as does the Plan Administrator.

INCENTIVES TO PROVIDERS

In-Network Providers may be provided financial incentives by Oxford to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for In-Network Providers are:

- ▶ bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- ▶ a practice called capitation which is when a group of In-Network Providers receives a monthly payment from Oxford for each Covered Person who selects an In-Network Provider within the group to perform or coordinate certain health services. The In-Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the

Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your In-Network Provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your In-Network Provider.

INCENTIVES TO YOU

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but the Plan recommends that you discuss participating in such programs with your Physician. These incentives are not benefits and do not alter or affect your benefits. You may call the number on the back of your ID card if you have any questions.

REBATES AND OTHER PAYMENTS

The Plan and Oxford may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a hospital or alternate facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. MPIHP and Oxford may pass a portion of these rebates on

to you. When rebates are passed onto you, they may be taken into account in determining your Copayment and/or Coinsurance.

WORKERS' COMPENSATION

Injuries and diseases covered under any Workers' Compensation program are excluded from coverage.

Glossary

WHAT THIS

SECTION INCLUDES:

- Definitions of terms used throughout this Supplement.

Many of the terms used throughout this Supplement may be unfamiliar to you or have a specific meaning.

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

Addendum – Any attached written description of additional or revised provisions to Oxford. The benefits and exclusions of this Supplement and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and Supplement and/or Amendments to the Supplement, the Addendum shall be controlling.

Ambulatory Surgical Centers – A facility currently licensed by the appropriate state regulatory agency for the provisions of surgical and related medical services on an outpatient basis.

Amendment – Any attached written description of additional or alternative provisions to Oxford. Amendments are effective only when distributed by the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of Oxford, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – The amount you must pay for Covered Services in

a calendar year before the Plan will begin paying Out-of-Network Benefits in that calendar year.

Autism Spectrum Disorders – The pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, including but not limited to Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

Behavioral Therapy – Any interactive behavioral therapies derived from evidence-based research, including, but not limited to, Applied Behavior Analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with ASD that are:

- provided to children less than fifteen years of age; and
- provided or supervised by a behavior analyst who is certified by the Behavior Analyst Certification Board, a licensed physician or a licensed psychologist.

Behavior Therapy is considered to be supervised by a behavior analyst, licensed physician or licensed psychologist when the supervision entails at least one hour of face-to-face supervision of the autism services provided for each ten hours of Behavioral Therapy.

Benefits – Oxford payments for Covered Services, subject to the

terms and conditions of the Plan and any Addendums and/or Amendments.

Cellular Therapy – Administration of living whole cells into a patient for the treatment of disease.

Claims Administrator – Oxford and its affiliates, who provide certain claim administration.

Clinical Trial – A scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

Coinsurance – The percentage of Eligible Expenses you are required to pay for certain Covered Services.

Congenital Anomaly – A physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Co-Payment – The set dollar amount you are required to pay for certain Covered Services.

Cosmetic Procedures – Procedures or services that change or improve appearance without significantly improving physiological function, as determined by Oxford. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Covered or Covered Services – The Medically Necessary services paid for or arranged for you by

Oxford under the terms and conditions of this Supplement.

Covered Person – Either the Participant or an enrolled Dependent only while enrolled and eligible for benefits under Oxford. References to “you” and “your” throughout this Supplement are references to a Covered Person.

Custodial Care – Services that do not require special skills or training and that:

- ▶ provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- ▶ are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- ▶ do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – The amount you owe before Oxford begins to pay for Covered Services. The Deductible applies before any Co-payments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that you owe before the Plan begins to pay for a particular Covered Service.

Durable Medical Equipment (DME) – Medical equipment that is

all of the following:

- ▶ used to serve a medical purpose with respect to treatment of a sickness, injury or their symptoms;
- ▶ not disposable;
- ▶ not of use to a person in the absence of a Sickness, Injury or their symptoms;
- ▶ durable enough to withstand repeated use;
- ▶ not implantable within the body; and
- ▶ appropriate for use, and primarily used, within the home.

Eligible Expenses – Charges for Covered Services that are provided while the Plan is in effect. For certain Covered Services, you are required to pay a percentage of Eligible Expenses in the form of a Co-Payment and/or Coinsurance. Eligible Expenses are subject to Oxford’s reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from Oxford.

Emergency – A serious medical condition or symptom resulting from injury, sickness or mental illness, or substance use disorders which:

- ▶ arises suddenly; and
- ▶ in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services – Health care services and supplies necessary for the treatment of an emergency.

Employee Retirement Income Security Act of 1974 (ERISA) – The

federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

EOB – See Explanation of Benefits (EOB).

ERISA – See Employee Retirement Income Security Act of 1974 (ERISA).

Exclusions – What Oxford does not cover as a Covered Service.

Experimental or Investigational Services – Medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time Oxford makes a determination regarding coverage in a particular case, are determined to be any of the following:

- ▶ not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use;
- ▶ subject to review and approval by any institutional review board for the proposed use (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
- ▶ the subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- ▶ Clinical Trials for which benefits are available as described under Clinical Trials in Section 5, *Covered Services*.
- ▶ If you are not a participant in a qualifying Clinical Trial as described under in Section 5, *Covered Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) –

A statement provided by Oxford to you, your Physician, or another health care professional that explains:

- ▶ the benefits provided (if any);
- ▶ the allowable reimbursement amounts;
- ▶ Deductibles;
- ▶ Coinsurance;
- ▶ any other reductions taken;
- ▶ the net amount paid by the Plan; and
- ▶ the reason(s) why the service or supply was not covered by the Plan.

Gender Dysphoria – A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- ▶ Diagnostic criteria for adults

and adolescents:

A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
- A strong desire for the primary and/or secondary sex characteristics of the other gender.
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

- ▶ Diagnostic criteria for children:

A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):

- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
- In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
- A strong preference for cross-gender roles in make-believe play or fantasy play.
- A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
- In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
- A strong dislike of one's sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

The condition is associated with clinically significant distress or

impairment in social, school or other important areas of functioning.

Gene Therapy – Therapeutic delivery of nucleic acid (DNA or RNA) into a patient’s cells as a drug to treat a disease.

Gestational Carrier – A female who becomes pregnant when a fertilized egg (embryo) is implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

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

Health Care Professional – An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified Health Care Professional under applicable law that requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional’s services must be rendered within the lawful scope of practice for that type of Provider in order to be covered.

Home Health Agency – A program or organization authorized by law to provide health care services in the home.

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

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

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

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

Hospitalization – Care in a hospital that requires admission as

an inpatient and usually requires an overnight stay.

In-Network Co-Payment – A fixed amount you pay directly to an In-Network Provider for a Covered Service when you receive the Covered Service. The amount can vary by the type of Covered Service.

In-Network Provider – A Physician, Certified Nurse Midwife, hospital, Skilled Nursing Facility, Home Health Care Agency, or any other duly licensed or certified institution or health professional under contract with Oxford to provide Covered Services to Participants. A list of In-Network Providers and their locations are available to you upon enrollment or upon request. This list will be revised from time to time by Oxford.

Injury – Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility – A long term acute rehabilitation center, a hospital (or a special unit of a hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay – An uninterrupted confinement, following formal admission to a hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intermediate Care: Mental Health or Substance Use Disorder treatment that encompasses the following:

- ▶ Care at a Residential Treatment Facility.

- ▶ Care at a Partial Hospitalization/ Day Treatment program.
- ▶ Care through an Intensive Outpatient Treatment program.

Intensive Outpatient Treatment: a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or hospital-based and provides services for at least three hours per day, two or more days per week.

Medicaid – A federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program’s costs.

Medically Necessary – Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, mental illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by Oxford or its designee, within Oxford’s sole discretion. The services must be:

- ▶ in accordance with *Generally Accepted Standards of Medical Practice*;
- ▶ clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, mental illness, substance use disorder disease or its symptoms;
- ▶ not mainly for your convenience or that of your doctor or other health care Provider; and
- ▶ not more costly than an alternative drug, service(s) or supply that is at least as likely to

produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. Oxford reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within Oxford’s sole discretion.

Oxford develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by Oxford and revised from time to time), are available to Covered Persons on www.oxhp.com or by calling the number on your ID card.

Medicare – Parts A, B, C and D of the insurance program established

by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services – Covered Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Service.

Mental Illness – Those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the this Supplement.

Network – When used to describe a Provider of health care services, this means a Provider that has a participation agreement in effect (either directly or indirectly) with Oxford or with its affiliate to participate in the Network.

Out-of-Network Coinsurance – Your share of the costs of a Covered Service, calculated as a percent of the Eligible Expense for the Covered Service that you are required to pay to an Out-of-Network Provider.

Out-of-Network Co-Payment – A fixed amount you pay directly to an Out-of-Network Provider for a Covered Service when you receive the Covered Service. The amount can vary by the type of Covered Service.

Out-of-Network Deductible – The amount you owe before Oxford begins to pay for Covered Services received from Out-of-Network Providers. The Out-of-Network Annual Deductible

applies before any Coinsurance or Co-Payments are applied. The Out-of-Network Annual Deductible may not apply to all Covered Services. You may also have an Out-of-Network Annual Deductible that applies to a specific Covered Service (for example, a Prescription Drug Deductible) that you owe before the Plan begins to pay for a particular Covered Service.

Out-of-Network Out-of-Pocket Limit – The most you pay in cost-sharing before the Plan begins to pay 100% of the Eligible Expense for Covered Services received from Out-of-Network Providers. This maximum never includes your premium, Balance Billing charges or services Oxford does not cover. You are also responsible for all differences, if any, between the Eligible Expense and the Out-of-Network Provider's charge for Out-of-Network services regardless of whether the Out-of-Pocket Annual Maximum has been met.

Out-of-Network Provider – A Provider who does not have a contract with Oxford to provide services to you. You will pay more to see an Out-of-Network Provider.

Out-of-Pocket Limit – The maximum amount you pay in cost-sharing before Oxford begins to pay 100% of the Eligible Expenses for Covered Services. This limit never includes your premium, Balance Billing charges or the cost of health care services Oxford does not cover. Refer to the *Plan Highlights* for the Out-of-Pocket Limit amount.

Partial Hospitalization/Day Treatment – A structured ambulatory program that may be a free-standing or hospital-based program and that provides services for at least 20 hours per week.

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

Plan – The Motion Picture Industry Health Plan.

Plan Administrator – The Motion Picture Industry Health Plan or its designee.

Preauthorization – Enables Oxford to review the Medical Necessity of a proposed service or treatment including the determination of a proposed site of care, manage benefit limitations, and whether the service will be performed by an In-Network Provider. Preauthorization allows Oxford to notify the Participant or the Participant's Provider regarding coverage before the service is provided.

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

Primary Care Physician ("PCP") – An In-Network Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for you.

Provider – A Physician, Health Care Professional or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a

vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this Supplement that is licensed, registered, certified or accredited as required by state law.

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

Schedule of Benefits – The section of this Supplement that describes the Co-Payments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements and other limits on Covered Services.

Semi-private Room – A room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Services – The Medically Necessary services paid for or arranged for you by Oxford under the terms and conditions of this Supplement.

Service Area – The geographical area, designated by Oxford and approved by the State of New York in which Oxford provides coverage. Oxford's Service Area consists of the following counties: Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster and Westchester.

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

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

Substance Use Disorder

Services – Covered Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Service.

Surrogate – A female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. The surrogate provides the egg and is therefore biologically (genetically) related to the child.

Transitional Care – Mental Health Services and Substance Use

Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- ▶ Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment does not offer the intensity and structure needed to assist the Member with recovery.
- ▶ Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment does not offer the intensity and structure needed to assist the Member with recovery.

Unproven Services – Health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- ▶ Well-conducted randomized controlled trials are two or more treatments compared to

each other, with the patient not being allowed to choose which treatment is received).

- ▶ Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Oxford has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, Oxford issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.oxhp.com.

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

Urgent Care Center – A licensed facility (other than a hospital) that provides Urgent Care.

Usual, Customary and

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

Utilization Review – The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

ATTACHMENT I

Gym Reimbursement

COVERAGE FOR EXERCISE FACILITY REIMBURSEMENT

1 General

Oxford will partially reimburse you for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities, and which maintain equipment and programs that promote cardiovascular wellness.

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual work-out visits. Oxford will not provide

reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (massages etc.).

In order to be eligible for reimbursement, you must:

- Be an active member of the exercise facility.
- Complete 50 visits in a six-month period.
- In order to obtain reimbursement, at the end of the six-month period you must:
- Submit a completed reimbursement form.
- Submit a copy of your current

facility bill which shows the fee paid for your membership.

Once Oxford receives the completed reimbursement form and the bill, you will be reimbursed as identified on the *Schedule of Benefits* in Section 4, *Plan Highlights*.

2 Other Terms of Coverage

All other terms, conditions, limitations and exclusions of Oxford remain in full force and effect except as specifically modified by this attachment.

ATTACHMENT II

Hemophilia Factor Benefits

A. Hemophilia: *a group of disorders that share the inability to form a proper blood clot. They are characterized by extended bleeding after injury, surgery, trauma or menstruation. Sometimes the bleeding is spontaneous, without a known or identifiable cause. Improper clotting can be caused by defects in blood components such as platelets and/or clotting proteins, also called clotting factors. The body produces 13 clotting factors. If any of them are defective or deficient, blood clotting is affected; a mild, moderate or severe

bleeding disorder can result.

The following Covered Services for clotting factor are available only when provided by the specific In-Network Providers listed below:

1 Prescription Drug Coverage for clotting factor provided by an In-Network Hemophilia Treatment Center

Oxford covers Hemophilia clotting factor that you self-administer or is administered by a non-skilled caregiver when it would otherwise be covered under your Prescription Drug benefits and it is dispensed

by an In-Network Hemophilia Treatment Center as part of your written treatment plan. This Covered Service will be provided in lieu of receiving clotting factor dispensed by a designated pharmacy under your Prescription Drug Coverage benefit. A "Hemophilia Treatment Center" (HTC) means a unique federally funded entity that specializes in comprehensive care for pediatric and adult individuals with inherited bleeding and clotting disorders. An HTC must be a licensed facility that is also

designated as a comprehensive hemophilia diagnostic treatment center receiving a grant under Section 501(a) (2) of the Social Security Act and participates in the 340B Drug Pricing Program.

Your cost-sharing for clotting factor dispensed by an HTC will be covered is the cost-sharing amount, if any, that applies to intravenous or injectable chemotherapy agents covered under the Outpatient and Professional Services section of this Supplement.

2 Non-Emergent Home Health Care - Assisted Administration of Factor

In addition to the Home Health Care benefits available under your Supplement, the Plan will cover non-emergent administration of Hemophilia Factor in your home when provided by an In-Network Home Health Agency certified or licensed by the appropriate state agency. This additional Home Health Care benefit covers both the clotting factor and the administration services when assisted administration is Medically Necessary. Coverage will be provided in lieu of receiving Medically Necessary covered assisted-administration service from your Physician or another health practitioner in an office or out-patient setting.

Any visits for assisted administration of Hemophilia clotting factor in your home count toward your Home Health Care visit limit. Your cost-sharing and definition of a visit in the Home Health Care benefits shall apply to these additional services. See your

Schedule of Benefits in your Motion Picture Industry Health Plan SPD for Active Participants and Home Health Care Covered Service for more information. Please note this benefit only provides coverage for assisted administration of clotting factor. It does not cover clotting factor that you self-administer or that is administered by a non-skilled caregiver.

3 Preauthorization

The Covered Services covered under this Section require Preauthorization. Your Provider must call Oxford at the number indicated on your ID card.

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

4 Exclusions and limitations

Except as expressly modified by this section, all of the Exclusions and limitations of the Supplement apply to the Covered Services under covered by this section.

5 Controlling Contract

All of the terms, conditions, limitations, and exclusions of your Supplement shall also apply to this Section except where specifically changed by this Section.

*Some bleeding disorders, such as hemophilia, can be inherited or acquired. Others can occur from such conditions as anemia, cirrhosis of the liver, HIV, leukemia and vitamin K deficiency. They also

can result from certain medications that thin the blood, including aspirin, heparin and warfarin.

Treatment for bleeding disorders varies, depending on the condition and its severity. For some bleeding disorders, there are clotting factor concentrates that can be infused prophylactically or on-demand at home, to prevent or treat bleeds. For other bleeding disorders, there are topical products, nasal sprays and fresh frozen plasma, which is administered in a hospital setting.

Nondiscrimination & Accessibility Requirements

When the Plan uses the words “Oxford” in this attachment, it is a reference to Oxford Health Plans LLC, on behalf of itself and its affiliated companies.

Oxford, on behalf of itself and its affiliated companies, complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Oxford does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Oxford provides free aids and services to people with disabilities to communicate effectively with us, such as:

- ▶ Qualified sign language interpreters
- ▶ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- ▶ Free language services to people whose primary language is not English, such as: qualified interpreters
- ▶ Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan.

If you believe that Oxford has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you

can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

CLAIMS ADMINISTRATOR CIVIL RIGHTS COORDINATOR

Oxford Health Plans LLC Civil Rights Coordinator

Oxford Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130
The toll-free member phone number listed on your health plan ID card, TTY 711
UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human Services online, by phone or mail:

Online:
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone:
Toll-free (800) 368-1019
(800) 537-7697 (TDD)

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



PARTICIPANT SERVICES CENTER

Email

service@mpiphp.org

Call Toll-Free

(855) ASK-4MPI or

(855) 275-4674

Hours: 6 am to 7 pm

(Pacific Time)

Fax

(818) 766-1229 – California

(212) 634-4952 – New York

Website

www.mpiphp.org

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Hours: 9 am to 5 pm

(Eastern Time)



August 18, 2021

Dear Participant:

RE: Notice of Summary of Material Modification

Please note the following change to the Oxford Health Plans' Summary Plan Description effective September 1, 2021:

On page 29, Number 2 under, "Autism Spectrum Disorder, Except as Specifically Provided Under this Supplement," is changed to "Applied Behavioral Analysis is not covered."

In addition, the term, "Behavioral Therapy," is removed from the Glossary.

Please feel free to contact the Oxford Health Plans' customer service department at (800) 444-6222 with any questions.

Sincerely,

Participant Services Center