The Schedule of Benefits is a summary of services that may be covered under the plan. Benefits listed are subject to all provisions and limitations as outlined in the Evidence of Coverage (EOC). Please reference the EOC for details regarding the benefits listed below. The member is responsible for deductible, copayment or coinsurance applied to eligible service expenses. For services that require prior authorization, network providers must obtain authorization from us prior to providing a service or supply to a member. You should confirm with your provider that they have received prior authorization for a covered service prior to your treatment. An overview of Preventive Services covered with no cost share can be found within your EOC.

Pursuant to the Federal No Surprises Act, you are only required to pay the in-network cost sharing for non-network claims for care rendered in a state other than Washington for emergency care including post stabilization services; air ambulance services; for certain ancillary services provided by non-network providers at in-network facilities; and for covered services by a non-network provider at an in-network facility when you do not provide informed consent. Charges you incur for services from a non-network provider that fall in the scenarios listed above will accumulate towards your in-network deductible and/or maximum out-of-pocket amount. Please refer to your EOC for further information.

Pursuant to the Federal No Surprises Act and Washington Balance Billing Protection Act (BBPA), you are only required to pay the in-network cost sharing for non-network claims for care rendered in Washington state for, including but not limited to, emergency care including post stabilization services, non-emergency surgical or ancillary services at an in-network Hospital or Ambulatory Surgical Center, and air or ground ambulance services. Charges you incur for services from a non-network provider that fall in the scenarios listed above will accumulate towards your in-network deductible and/or maximum out-of-pocket amount. Please refer to your EOC for further information.

Ambetter from Coordinated Care Corporation

Ambetter Balanced Care 4-Standard Silver On Exchange Plan

Benefit	Insured Responsibility (per person) In-Network Providers	Insured Responsibility (per person) Out-of-Network Providers
Annual Deductible per Calendar Year	$8,200 Individual $16,400 Family	Not applicable Individual Not applicable Family
Coinsurance for Eligible Expenses (unless otherwise noted)	0% Coinsurance	Not applicable
Out-of-Pocket Maximum per Calendar Year	$8,200 Individual $16,400 Family	Not applicable Individual Not applicable Family
Provider Office Services	**Insured Responsibility (per person) In-Network Providers**	**Insured Responsibility (per person) Out-of-Network Providers**
Primary Care Office Visit	$30 Copay per visit	Not covered
Specialist Office Visit	$60 Copay per visit	Not covered
Telemedicine Visits	No charge	Not covered
Preventive Care (including screenings, immunizations and well-baby visits) Covered in accordance with ACA guidelines.	No charge	Not covered
Diagnostic Test* (x-ray)	No charge after deductible	Not covered
Diagnostic Test* Lab-work/Other (e.g., bloodwork, EKG, Stress Test)	No charge after deductible	Not covered
Imaging Test* (CT/PET scans, MRI)	No charge after deductible	Not covered
Prescription Drugs	**Insured Responsibility (per person) In-Network Providers**	**Insured Responsibility (per person) Out-of-Network Providers**
Tier 1a: Preferred Generic	$3 Copay per prescription	Not covered
Tier 1b: Generic*	$15 Copay per prescription	Not covered
Tier 2: Preferred Brand*	$50 Copay per prescription	Not covered
Tier 3: Non-Preferred Brand and Non-Preferred Generic*	No charge after deductible	Not covered
Tier 4: Specialty*	No charge after deductible	Not covered

*Prior authorization may be required. Please contact Member Services at the number listed on your member identification card to determine if prior authorization is needed.

Note: Cost share for covered services is based on place of service.

Prescription Drugs	Insured Responsibility (per person) In-Network Providers	Insured Responsibility (per person) Out-of-Network Providers
Mail Order (90-day supply) – Preferred Generic	$7.50 Copay per prescription	Not covered
Mail Order* (90-day supply) – Generic	$37.50 Copay per prescription	Not covered
Mail Order* (90-day supply) – Preferred Brand	$125 Copay per prescription	Not covered
Mail Order* (90-day supply) – Non – Preferred Brand and Non-Preferred Generic	No charge after deductible	Not covered
Mail Order* (30-day supply) – Specialty	No charge after deductible	Not covered
Insulin medications are covered with a maximum cost share of $35 per 30-day supply. Any Cost Sharing paid will apply toward the annual Deductible.		
Asthma inhalers (at least one covered inhaled corticosteroid and at least one inhaled corticosteroid combination product) are covered with a maximum Cost Share of $35 per 30-day supply, not subject to Deductible. Any Cost Sharing paid will apply toward the annual Deductible. Please refer to the formulary for additional information.		
Epinephrine autoinjectors (at least one covered epinephrine autoinjector product containing at least two autoinjectors) are covered with a maximum Cost Share of $35, not subject to Deductible. Any Cost Sharing paid will apply toward the annual Deductible. Please refer to the formulary for additional information.		
Outpatient Services	**Insured Responsibility (per person) In-Network Providers**	**Insured Responsibility (per person) Out-of-Network Providers**
Outpatient Facility*	No charge after deductible	Not covered
Outpatient Surgery Physician/Surgical Services*	No charge after deductible	Not covered
Emergency and Urgent Care Services	**Insured Responsibility (per person) In-Network Providers**	**Insured Responsibility (per person) Out-of-Network Providers**
Emergency Room	No charge after deductible	No charge after deductible
ER Physician Fee	No charge after deductible	No charge after deductible
Emergency Transportation/Ambulance (Air, Water or Ground) Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization.	No charge after deductible	No charge after deductible
Urgent Care	$50 Copay per visit	Not covered
Inpatient Hospital Services	**Insured Responsibility (per person) In-Network Providers**	**Insured Responsibility (per person) Out-of-Network Providers**
Inpatient Hospital Facility*	No charge after deductible	Not covered
Inpatient Hospital Physician and Surgical Services*	No charge after deductible	Not covered
Behavioral Health Treatment: Mental Health and Substance Use Disorder Services	**Insured Responsibility (per person) In-Network Providers**	**Insured Responsibility (per person) Out-of-Network Providers**
Behavioral Health Outpatient Services* (PCP and other practitioner office visits do not require prior authorization.)	$30 Copay per visit; No charge after deductible; for other outpatient services	Not covered
Behavioral Health Inpatient Services*	No charge after deductible	Not covered
Behavioral Health Emergency Room	No charge after deductible	No charge after deductible
Behavioral Health ER Physician Fee	No charge after deductible	No charge after deductible
Behavioral Health Emergency Transportation/Ambulance (Air, Water or Ground) Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization.	No charge after deductible	No charge after deductible
Behavioral Health Urgent Care	$30 Copay per visit	Not covered

*Prior authorization may be required. Please contact Member Services at the number listed on your member identification card to determine if prior authorization is needed.

Note: Cost share for covered services is based on place of service.

Behavioral Health Treatment: Mental Health and Substance Use Disorder Services	Insured Responsibility (per person) In-Network Providers	Insured Responsibility (per person) Out-of-Network Providers
Behavioral Health Laboratory Services*	No charge after deductible	Not covered
Behavioral Health Habilitation Outpatient Services* (including occupational, speech, and physical therapy)	No charge after deductible	Not covered
Behavioral Health Habilitation Inpatient Services* (including occupational, speech, and physical therapy)	No charge after deductible	Not covered
Maternity and Newborn Care	**Insured Responsibility (per person) In-Network Providers**	**Insured Responsibility (per person) Out-of-Network Providers**
Prenatal and Postnatal Care Covered in accordance with ACA guidelines.	No charge	Not covered
Delivery and Inpatient Services*	No charge after deductible	Not covered
Termination of Pregnancy	No charge	No charge
Other Covered Services	**Insured Responsibility (per person) In-Network Providers**	**Insured Responsibility (per person) Out-of-Network Providers**
Home Health Care Services* Limited to 130 visits per year.	No charge after deductible	Not covered
Rehabilitation Outpatient Services* (including speech, occupational and physical therapy) Limited to 25 outpatient visits per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.	No charge after deductible	Not covered
Rehabilitation Inpatient Services* (including speech, occupational and physical therapy) Limited to 30 days per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.	No charge after deductible	Not covered
Habilitation Outpatient Services* (including speech, occupational and physical therapy) Limited to 25 outpatient visits per year.	No charge after deductible	Not covered
Habilitation Inpatient Services* (including speech, occupational and physical therapy) Limited to 30 days per year.	No charge after deductible	Not covered
Extended Care Facility* Limited to 60 days per year.	No charge after deductible	Not covered
Durable Medical Equipment*	No charge after deductible	Not covered
Hospice Services* Limited to 14 days per lifetime for respite care covered in conjunction with hospice services.	No charge after deductible	Not covered
Chiropractic Care* Limited to 10 visits per year.	$60 Copay per visit	Not covered
Acupuncture	$60 Copay per visit	Not covered
Routine Foot Care*	$60 Copay per visit	Not covered

*Prior authorization may be required. Please contact Member Services at the number listed on your member identification card to determine if prior authorization is needed.
Note: Cost share for covered services is based on place of service.

Other Covered Services	Insured Responsibility (per person) In-Network Providers	Insured Responsibility (per person) Out-of-Network Providers
Transplant Benefit* Note: Limited to $10,000 for transportation & lodging per transplant; $30,000 for donor search per transplant.	No charge after deductible	Not covered
Hearing Exam*	$60 Copay per visit	Not covered
Bone Anchored Hearing Aids (BAHA)/Cochlear Implants*	No charge	Not covered
Hearing Aids* Limited to 1 per ear every 3 years.	No charge	Not covered
Diabetes Care Management	$60 Copay per visit	Not covered
Inherited Metabolic Disorder – PKU*	No charge after deductible	Not covered
Sleep Study*	No charge after deductible	Not covered
Neurodevelopmental Therapy* Limited to 30 inpatient days per year and 25 outpatient visits per year (speech, occupational and physical therapy combined). Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.	No charge after deductible	Not covered
Nutritional Counseling*	$60 Copay per visit	Not covered
Temporomandibular Joint (TMJ) and Craniomandibular Joint (CMJ) Disorders*	No charge after deductible	Not covered
Infertility Treatment* Coverage includes artificial insemination only.	No charge after deductible	Not covered
Cancer Chemotherapy*	No charge after deductible	Not covered
Vision Services – Pediatric (Children under the age of 19)	**Insured Responsibility (per person) In-Network Providers**	**Insured Responsibility (per person) Out-of-Network Providers**
Exam		
Routine eye exam (& contact lens fitting) Limited to 1 visit per year.	100% Covered	Not covered
Comprehensive Eye Exam 1 visit per year	100% Covered	Not covered
Frame		
Eyeglasses (frames) Limited to 1 item per year. Limited to one frame and one pair (two lenses) per calendar year or contacts in lieu of glasses.	100% Covered	Not covered
Lenses (per pair)		
Prescription lenses (including additional lens options)	100% Covered	Not covered
Contact lenses (in lieu of glasses)	100% Covered	Not covered
Low vision evaluation and aids	100% Covered	Not covered
High power spectacles, magnifiers, and telescopes	100% Covered	Not covered

*Prior authorization may be required. Please contact Member Services at the number listed on your member identification card to determine if prior authorization is needed.
Note: Cost share for covered services is based on place of service.

*Prior authorization may be required. Please contact Member Services at the number listed on your member identification card to determine if prior authorization is needed.
Note: Cost share for covered services is based on place of service.

English:	If you, or someone you are helping, have questions about Ambetter from Coordinated Care Corporation, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-877-687-1197 (TTY 711).
Amharic:	እርስዎ ወይም ሌላ የሚያግዙት ሰው፣ ስለ Ambetter from Coordinated Care Corporation ጥያቄ ካለዎት እና እንግሊዝኛ ብቁ ካልሆኑ፣ ያለምንም ወጪ እና በጊዜው በቋንቋዎ እርዳታ እና መረጃ የማግኘት መብት አልዎት። እርስዎ ወይም ሌላ የሚያግዙት ሰው፣ ግንኙነትን የሚያደናቅፍ የመስማት እና/ወይም የእይታ ችግር ካልዎት፣ አጋዥ እርዳታዎችን እና አገልግሎቶችን ያለ ምንም ወጪ እና በጊዜው የመቀበል መብት አልዎት። የትርጉም ወይም ረዳት አገልግሎቶችን ለማግኘት እባክዎ በ 1-877-687-1197 (TTY 711) የአባል አገልግሎቶች ን ያናግሩ።
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Coordinated Care Corporation، ولم تكن بارعًا باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعده تعاني من حالة سمعية و/أو بصرية تعيق التواصل، فلديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال بـ خدمات الأعضاء على 1-877-687-1197 (TTY 711).
Burmese:	အကယ်၍ သင် သို့မဟုတ် သင်ကူညီနေသူတစ်ဦးသည် Ambetter from Coordinated Care Corporation အကြောင်းနှင့် ပတ်သက်၍ မေးခွန်းများ မေးလိုပြီး အင်္ဂလိပ်လို ကျွမ်းကျင်စွာ မပြောနိုင်ပါက၊ သင့်တွင် အကူအညီနှင့် အချက်အလက်များကို သင့်ဘာသာစကားဖြင့် အခကြေးငွေ ပေးစရာမလိုဘဲ အချိန်နှင့်တစ်ပြေးညီ ရယူပိုင်ခွင့်ရှိသည်။ အကယ်၍ သင် သို့မဟုတ် သင်ကူညီနေသူတစ်ဦးသည် ဆက်သွယ်ရေးကို အဟန့်အတားဖြစ်စေသော အကြားအာရုံ နှင့်/သို့မဟုတ် အမြင်အာရုံနှင့် သက်ဆိုင်သော အခြေအနေတစ်ခုရှိပါက၊ သင့်တွင် အရန်အကူအညီများနှင့် ဝန်ဆောင်မှုများကို အခကြေးငွေ ပေးစရာမလိုဘဲ အချိန်နှင့်တစ်ပြေးညီ ရယူပိုင်ခွင့်ရှိသည်။ ဘာသာပြန် သို့မဟုတ် အရန်ဝန်ဆောင်မှုများကို လက်ခံရယူရန် 1-877-687-1197 (TTY 711) ရှိ အဖွဲ့ဝင် ဝန်ဆောင်မှုများကို ဆက်သွယ်ပါ။
Mon-Khmer, Cambodian:	ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពី Ambetter from Coordinated Care Corporation ហើយមិនមានភាពស្ទាត់ជំនាញក្នុងការប្រើភាសាអង់គ្លេស អ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ និងទៅតាមពេលវេលាសមស្រប។ ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានបញ្ហាគំហើញ និង/ឬការស្ទាប់ដែលរារាំងដល់ការទំនាក់ទំនង អ្នកមានសិទ្ធិទទួលបានជំនួយ និងសេវាកម្មចាំបាច់នានាដោយឥតគិតថ្លៃ និងក្នុងពេលវេលាសមស្រប។ ដើម្បីទទួលបានសេវាកម្មបកប្រែ ឬសេវាកម្មចាំបាច់នានា សូមទាក់ទង សេវាកម្មសមាជិក តាមរយៈលេខ 1-877-687-1197 (TTY 711)។
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Coordinated Care Corporation 方面的問題，且不精通英語，您有權利免費並及時以您的母語獲幫助和訊息。如果您，或您正在協助的對象有聽力和/或視力上的問題，阻礙了溝通，您有權利免費並及時獲得輔助支援與服務。若要取得翻譯或輔助服務，請聯絡會員服務部，電話是 1-877-687-1197 (TTY 711)。
Farsi Persian:	اگر شما یا فردی که دارید به او کمک می‌کنید، سؤالی درباره Ambetter from Coordinated Care Corporation دارید، و انگلیسی نمی‌دانید، حق دارید کمک و اطلاعات را به زبان خودتان به رایگان و به موقع دریافت کنید. اگر شما یا فردی که دارید به او کمک می‌کنید مشکلات شنوایی یا بینایی دارد که برقراری ارتباط را سخت می‌کند، حق دارید کمک‌ها و خدمات امدادی را به زبان خودتان به رایگان و به موقع دریافت کنید. برای دریافت کمک‌ها و خدمات امدادی لطفاً با خدمات اعضا به شماره 1-877-687-1197 (TTY 711) تماس بگیرید.
French:	Si vous même ou une personne que vous aidez avez des questions à propos d'Ambetter from Coordinated Care Corporation et que vous ne maîtrisez pas l'anglais, vous pouvez bénéficier gratuitement et en temps utile d'aide et d'informations dans votre langue. Si vous même ou une personne que vous aidez souffrez d'un trouble auditif ou visuel qui entrave la communication, vous pouvez bénéficier gratuitement et en temps utile d'aides et de services auxiliaires. Pour profiter de services de traduction ou de services auxiliaires, veuillez contacter Services aux membres au 1-877-687-1197 (TTY 711).

Korean:	귀하 또는 귀하의 도움을 받는 분이 Ambetter from Coordinated Care Corporation에 대한 질문이 있는 경우 영어에 능숙하지 않으시면 해당 언어로 시의적절하게 무료 지원과 정보를 받을 권리가 있습니다. 귀하 또는 귀하의 도움을 받는 분이 청각 및/또는 시각적으로 의사소통에 장애가 있는 경우 시의적절하게 무료 보조 도구 및 서비스를 받을 권리가 있습니다. 번역 또는 보조 서비스를 받으시려면 1-877-687-1197 (TTY 711)번으로 가입자 서비스부에 연락해주십시오.
Laotian:	ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Ambetter from Coordinated Care Corporation, ແລະ ບໍ່ຊ່ຽວຊານພາສາອັງກິດ, ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີສະພາບຫາງການໄດ້ຍິນ ແລະ/ຫຼື ການເບິ່ງເຫັນທີ່ຂັດຂວາງການສື່ສານ, ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ເພື່ອໃຫ້ໄດ້ຮັບການບໍລິການແປພາສາ ຫຼື ບໍລິການເສີມ, ກະລຸນາຕິດຕໍ່ຫາ Member Services (ການບໍລິການສະມາຊິກ) ໄດ້ທີ່ 1-877-687-1197 (TTY 711).
Pashto:	که تاسو، یا هغه څوک چې تاسو ورسره مرسته کوئ، د Ambetter from Coordinated Care Corporation په اړه پوښتنې لرئ او په انګلیسي ژبه کې مهارت نه لرئ، تاسو حق لرئ چې په خپله ژبه کې پرته له لګښت او په وخت سره مرسته او معلومات ترلاسه کړئ. که تاسو, یا هغه څوک چې تاسو ورسره مرسته کوئ، د اوریدو او/یا د لیدلو ستونزه لرئ چې د اړیکو مخه نیسي، تاسو حق لرئ چې مرستندویه مرستې او خدمات په وړیا توګه او په وخت سره ترلاسه کړئ. د ژباړې یا مرستندویه خدماتو ترلاسه کولو لپاره، مهرباني وکړئ د غړو خدماتو سره په 1-877-687-1197 (TTY 711) اړیکه ونیسئ.
Portuguese:	Se tiver dúvidas ou estiver a ajudar uma pessoa com dúvidas acerca do Ambetter from Coordinated Care Corporation e não falar inglês, tem direito a obter ajuda e informações no seu idioma, sem qualquer custo e de forma atempada. Se tiver uma condição visual e/ou auditiva que dificulte a comunicação ou estiver a ajudar uma pessoa com uma condição deste tipo, tem direito a receber equipamentos ou serviços de assistência, sem qualquer custo e de forma atempada. Para ter acesso a traduções ou a serviços de assistência, contacte os "Member Services" (Serviços de Membros) através do número 1-877-687-1197 (TTY 711).
Punjabi:	ਜੇ ਤੁਸੀਂ, ਜਾਂ ਤੁਹਾਡੇ ਦੁਆਰਾ ਮਦਦ ਕੀਤੇ ਜਾਣ ਵਾਲੇ ਕਿਸੇ ਵਿਅਕਤੀ ਦੇ Ambetter from Coordinated Care Corporation ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਅਤੇ ਤੁਸੀਂ ਅੰਗਰੇਜ਼ੀ ਵਿੱਚ ਮੁਹਾਰਤ ਨਹੀਂ ਰੱਖਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਦੇ ਅਤੇ ਸਮੇਂ ਸਿਰ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਜੇ ਤੁਹਾਨੂੰ, ਜਾਂ ਤੁਹਾਡੇ ਦੁਆਰਾ ਮਦਦ ਕੀਤੇ ਜਾਣ ਵਾਲੇ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਸੁਣਨ ਅਤੇ/ਜਾਂ ਦੇਖਣ ਸੰਬੰਧੀ ਕੋਈ ਸਮੱਸਿਆ ਹੈ, ਜੋ ਸੰਚਾਰ ਵਿੱਚ ਰੁਕਾਵਟ ਪਾਉਂਦੀ ਹੈ, ਤਾਂ ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਅਤੇ ਸਮੇਂ ਸਿਰ ਸਹਾਇਕ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਅਨੁਵਾਦ ਜਾਂ ਸਹਾਇਕ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-877-687-1197 (TTY 711) 'ਤੇ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਨਾਲ ਸੰਪਰਕ ਕਰੋ।
Russian:	Если у вас или у лица, которому вы помогаете, возникли какие-либо вопросы о программе страхования Ambetter from Coordinated Care Corporation, при этом вы недостаточно хорошо владеете английским языком, вы имеете право на бесплатную и своевременную помощь и информацию на своем родном языке. Если у вас или у лица, которому вы помогаете, наблюдается какое-либо нарушение слуха и/или зрения, которое препятствует коммуникации, вы имеете право на бесплатные и своевременные вспомогательные услуги и помощь. Для получения услуг перевода или вспомогательных услуг обратитесь в отдел обслуживания участников по номеру 1-877-687-1197 (TTY 711).
Somali:	Haddii adiga, ama qof aad caawinaysaa, uu qabo su’aalo ku saabsan Ambetter from Coordinated Care Corporation, oo aanu si wanaagsan ugu hadal Ingiriisiga, waxaad xaq u leedahay inaad hesho caawimo iyo macluumaad ah luqaddaada oo aan kharash ahayn iyo wakhti habboon. Haddii adiga, ama qof aad caawinayso, aad qabtaan xaalado maqalka ah iyo/ama araga ah oo xanibta wada xidhiidhka, waxaad xaq u leedahay inaad hesho kaalmada wada xidhiidhka iyo adeegyada oo aan kharash kugu joogin qaab wakhti habboon ah. Si aad u hesho turjumaad iyo adeegyada kaalmada wada xidhiidhka, fadlan la xidhiidh Adeegyada Xubinta lambarka 1-877-687-1197 (TTY 711).
Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Coordinated Care Corporation y no domina el inglés, tiene derecho a obtener ayuda e información en su idioma sin costo alguno y de manera oportuna. Si usted, o alguien a quien está ayudando, tiene un impedimento auditivo o visual que le dificulta la comunicación, tiene derecho a recibir ayuda y servicios auxiliares sin costo alguno y de manera oportuna. Para recibir servicios auxiliares o de traducción, comuníquese con Servicios para Miembros al 1-877-687-1197 (TTY 711).

Tagalog:	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Coordinated Care Corporation, at hindi ka mahusay sa Ingles, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos at sa maagap na paraan. Kung ikaw, o ang iyong tinutulungan, ay may kondisyon sa pandinig at/o pannikin na nakakaapekto sa komunikasyon, may karapatan kang makatanggap ng mga karagdagang tulong at serbisyo nang walang gastos at sa maagap na paraan. Para makatanggap ng mga serbisyo sa pagsasalin o mga karagdagang serbisyo, mangyaring makipag ugnayan sa Mga Serbisyo para sa Miyembro sa 1-877-687-1197 (TTY 711).
Tigrigna:	ባዕልኻ ወይ ንስኻ እትሕግዞ ሰብ ብዛዕባ ኣብ ትሕቲ Ambetter from Coordinated Care Corporation ዝመሓደር Ambetter ሕቶታት እንተልዮምኹም፣ ግን ከኣ ናይ ቋንቋ ኢንግሊኽ ብቕዓት እንድሕር ዝጎድለኩም ኩይኑ፣ ሓገዝን ሓበሬታን ብቓንቋኹም፣ ብናጻን ኣብ ትኽክለኛ እዋንን ክትረኽቡ መሰል ኣለኩም። ባዕልኻ ወይ ንስኻ እትሕግዞ ሰብ ክትረዳዳኡ ዝዕንቅፍ ናይ ምስማዕ ወይ ምርኣይ ጸገም እንተልዩኩም፣ ብናጻን ኣብ ሰዓቱን መስምዒ/መርኣዪ ሓገዛትን ኣገልግሎታትን ክትረኽቡ መሰል ኣለኩም። ናይ ትርጉም ወይድማ መስምዕዒ/መርኣዪ ሓገዛት ንምርካብ፣ በጃኻ ምስ ናይ ኣባላት ኣገልግሎታት ብ 1-877-687-1197 (TTY 711) ተራኽብ።
Ukrainian:	Якщо у вас або особи, якій ви допомагаєте, виникли запитання щодо плану Ambetter from Coordinated Care Corporation, але ви чи ця особа не володієте англійською мовою, ви маєте право отримати допомогу та інформацію своєю мовою безкоштовно й своєчасно. Якщо у вас або особи, якій ви допомагаєте, є вади слуху або зору, які заважають спілкуванню, ви маєте право отримати допоміжні засоби та послуги безкоштовно й своєчасно. Щоб отримати переклад або додаткові послуги, зв’яжіться зі Службою обслуговування учасників за номером 1-877-687-1197 (TTY 711).
Vietnamese:	Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Coordinated Care Corporation và không thành thạo tiếng Anh, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí và kịp thời. Nếu quý vị hoặc người mà quý vị đang giúp đỡ mắc bệnh về thính giác và/hoặc thị giác gây cản trở giao tiếp, quý vị có quyền được nhận các hỗ trợ và dịch vụ phụ trợ miễn phí và kịp thời. Để nhận dịch vụ thông dịch hoặc dịch vụ phụ trợ, vui lòng liên hệ bộ phận Dịch Vụ Thành Viên theo số 1-877-687-1197 (TTY 711).

Statement of Non-Discrimination

Ambetter from Coordinated Care Corporation complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity. Ambetter from Coordinated Care does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

Ambetter from Coordinated Care:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Ambetter from Coordinated Care at 1-877-687-1197 (TTY 711).

If you believe that Ambetter from Coordinated Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity, you can file a grievance with: Ambetter from Coordinated Care, 1557 Coordinator, P.O. Box 31384, Tampa, FL 33631, 1-855-577-8234 (TTY 711), Fax 1-866-388-1769, or email SM_Section1557Coord@centene.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Coordinated Care is available to help you.

You can also file a civil rights complaint with:

- The U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Ambetter from Coordinated Care is underwritten by Coordinated Care Corporation, which is a Qualified Health Plan issuer in the Washington Health Benefit Exchange. This is a solicitation for insurance. © 2025 Coordinated Care Corporation. All rights reserved. AmbetterHealth.com/en/wa

Declaración de no discriminación

Ambetter from Coordinated Care Corporation cumple las leyes federales y las leyes del estado de Washington vigentes sobre derechos civiles y no discrimina por motivos de origen racial, color, nacionalidad, edad, discapacidad, sexo, orientación sexual o identidad de género. Ambetter from Coordinated Care no excluye ni trata a las personas de manera menos favorable por motivos de origen racial, color, nacionalidad, edad, discapacidad, sexo, orientación sexual o identidad de género.

- Modificaciones razonables y ayudas y servicios auxiliares gratuitos y apropiados a personas con discapacidad para que puedan comunicarse eficazmente con nosotros, por ejemplo:
    - Intérpretes calificados de lengua de señas.
    - Información por escrito en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).

Si usted o alguien a quien ayuda tiene una condición auditiva o visual que impide la comunicación, tiene derecho a recibir ayudas y servicios auxiliares sin costo alguno y en el momento oportuno. Ambetter from Coordinated Care brinda:

- Servicios gratuitos de asistencia de idiomas a las personas cuya lengua materna no sea el inglés, por ejemplo:
    - Intérpretes calificados.
    - Información escrita en otros idiomas.

Si necesita modificaciones razonables, ayudas y servicios auxiliares apropiados o servicios de asistencia de idiomas, llame a Ambetter from Coordinated Care al 1-877-687-1197 (TTY 711).

Si cree que Ambetter from Coordinated Care no brindó estos servicios o discriminó de otro modo por motivos de origen racial, color, nacionalidad, edad, discapacidad, sexo, orientación sexual o identidad de género, puede presentar una queja: Ambetter from Coordinated Care, 1557 Coordinator, P.O. Box 31384, Tampa, FL 33631, 1-855-577-8234 (TTY 711), Fax 1-866-388-1769, o por correo electrónico a SM_Section1557Coord@centene.com. Puede presentar una queja en persona o por correo postal, fax o correo electrónico. Ambetter from Coordinated Care está disponible si necesita ayuda para presentar una queja.

También puede presentar un reclamo sobre los derechos civiles ante estos organismos:

- La Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. a través del portal en línea de la oficina para ese fin, en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o por correo o por teléfono: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Los formularios de reclamo están disponibles en http://www.hhs.gov/ocr/office/file/index.html.

- La Oficina del Comisionado de Seguros del Estado de Washington a través del portal en línea de la oficina para ese fin, en https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, o por teléfono al 800-562-6900 o al 360-586-0241 (TDD). Los formularios de reclamo están disponibles en https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Ambetter from Coordinated Care está cubierto por Coordinated Care Corporation, que es un emisor de planes de salud calificados en el Mercado de Beneficios de Salud de Washington. Esta es una solicitud de seguro. © 2025 Coordinated Care Corporation. Todos los derechos reservados. AmbetterHealth.com/es/wa

ambetter. FROM | coordinated care.





2026 EVIDENCE OF COVERAGE





AmbetterHealth.com/en/WA

COORDINATED CARE CORPORATION

Home Office: **1145 Broadway, Suite 700, Tacoma, WA 98402**

Individual Member HMO Contract

Ambetter from Coordinated Care

Coordinated Care Corporation (Ambetter from Coordinated Care) is a health maintenance organization (HMO) providing health care coverage for Members. In this Contract, the terms "you" or "your" refer to the Member or any dependents enrolled in this Contract. The terms "we," "our" or "us" refer to **Coordinated Care Corporation** or **Ambetter from Coordinated Care**.

AGREEMENT AND CONSIDERATION

This document along with the corresponding Schedule of Benefits is your Contract and it is a legal document. It is the agreement under which benefits will be provided and paid. In consideration of your application and timely payment of premiums, we will provide health care benefits to you, the Member, for Covered Services as outlined in this Contract. Benefits are subject to Contract definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

Annually, we must file this product, the Cost Share and the rates associated with it for approval. Guaranteed renewable means that your plan will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with Contract terms. You may keep this Contract (or the new Contract you are mapped to for the following year) in force by timely payment of the required premiums. In most cases you will be moved to a new Contract each year, however, we may decide not to renew the Contract as of the renewal date if:

1. we decide not to renew all Contracts issued on this form, with a new Contract at the same metal level with a similar type and level of benefits, to residents of the state where you then live;
2. we withdraw from the Service Area or reach demonstrated capacity in a Service Area in whole or in part; or
3. there is fraud or an intentional material misrepresentation made by or with the knowledge of a Member in filing a Claim for Covered Services.

In addition to the above, this guarantee for continuity of coverage shall not prevent us from cancelling or non-renewing this Contract in the following events:

1. non-payment of premium;
2. a Member fails to pay any Deductible or Copayment Amount owed to us and not the Provider of services;
3. a Member is found to be in material breach of this Contract; or
4. a change in federal or state law no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.

RIGHT TO RETURN CONTRACT

Please read your Contract carefully. If you are not satisfied, return this Contract to us or to our agent within 10 calendar days after you receive it. All premiums paid will be refunded back to the original method of payment and/or payor. The Contract will be considered null and void from the Effective Date. If we do not refund payments within 30 calendar days of timely receipt of the returned Contract, we will pay a penalty of 10 percent of such premium. We may reduce the refund by the value of services received during the period to which the refund applies.



Coordinated Care Corporation
Beth Johnson
CEO and Plan President

TABLE OF CONTENTS

INTRODUCTION **9**
How to Contact Us 9
Interpreter Services 10
MEMBER RIGHTS AND RESPONSIBILITIES **11**
IMPORTANT INFORMATION **15**
Provider Directory 15
Member Identification Card 16
Website 16
Quality Improvement 16
Protection from Balance Billing 17
DEFINITIONS **18**
MEMBER AND DEPENDENT COVERAGE **41**
Member Eligibility 41
Member and Dependent Member Effective Date 41
Coverage for a Newborn Child 41
Coverage for an Adopted Child 42
Adding Dependent Members 42
Commencement of Benefits for Persons Hospitalized on Effective Date 42
ELIGIBILITY AND ENROLLMENT **44**
For All Members 44
For Dependent Members 44
Open Enrollment 45
Special Enrollment Periods 45
Prior Coverage 47
PREMIUMS **48**
Premium Payment 48
Grace Period 48
Third-Party Payment of Premiums or Cost Sharing 49
Misstatement of Age 49
Change of Residence 49
Right to Change Premium 50
COST SHARING FEATURES **51**

Cost Sharing Features 51
Deductible 51
Copayments 51
Coinsurance Percentage 52
Maximum Out-of-Pocket 52
Non-Network Liability and Balance Billing 52
ACCESS TO CARE 53
Primary Care Provider 53
Contacting Your Primary Care Provider 53
Network Availability 54
Specialist Providers 54
Second Opinions 54
Emergency and Urgent Care 54
Non-Network Providers at Hospitals or Ambulatory Surgical Facilities 55
Transfer to Network Facility 55
Women's Health Care Direct Access Providers 55
Telemedicine and Virtual 24/7 Care 56
Service Area 56
Providers Outside of Washington 56
Continuity of Care 57
Hospital Based Providers 57
COVERED SERVICES 58
Acquired Brain Injury Services 58
Acupuncture 59
Alternative Care – Home Health Care or Hospice 59
Ambulance Service Benefits 60
Ambulatory Patient Services 62
Ambulatory Surgical Center 63
Autism Spectrum Disorder Benefits 63
Care Management Programs 63
Chiropractic Care 64
Clinical Trials 64
Colorectal Cancer Screening 65
Craniomandibular Joint (CMJ) and Temporomandibular Joint (TMJ) Dysfunction Conditions 66

Diabetes Coverage 66
Dialysis Services 67
Durable Medical Equipment (DME), Devices and Supplies 67
Emergency Services 71
Family Planning and Contraception Services 73
Fertility Preservation 75
Gender Affirming Treatment 75
Habilitation, Rehabilitation Facility and Extended Care Facility Benefits 75
Hearing Benefits 76
Home Health Care Service Benefits 77
Hospice Care Service Benefits 77
Hospital Services 78
Infertility Treatment Benefits 80
Lymphedema Benefit 80
Mammograms 80
Mastectomy and Breast Reconstruction 81
Medical and Surgical Services 81
Medical Dental Services – General Anesthesia and Facility Charges 85
Medical Foods 85
Medical Vision Services 87
Mental Health and Substance Use Disorder Benefits 87
Pediatric Vision Benefits – Children under the age of 19 89
Prescription Drug Benefits 91
Preventive Care Benefits 103
Maternity and Newborn Care 105
Prostate Cancer Screening 107
Radiology, Imaging and Other Diagnostic Testing 108
Routine Foot Care 108
Sleep Studies 108
Transplant Benefits 108
Urgent Care 112
Wellness Programs and Other Offerings 112
PRIOR AUTHORIZATION 114
Prior Authorization Required 114
Prior Authorization Requests 114

Prior Authorization Determination and Concurrent Inpatient Review and Notification 115
How to Obtain Prior Authorization 116
Emergency Services 116
Services from Non-Network Providers 116
GENERAL NON-COVERED SERVICES AND EXCLUSIONS 118
TERMINATION 122
Termination of Contract 122
Refund upon Termination 122
Discontinuance 122
Notification Requirements 123
REIMBURSEMENT AND SUBROGATION 124
COORDINATION OF BENEFITS 127
Definitions 127
Order of Benefit Determination Rules 129
Non-Dependent or Dependent 129
Child Covered Under More Than One Plan 129
Active Employee or Retired or Laid-off Employee 130
COBRA or State Continuation Coverage 131
Longer or Shorter Length of Coverage 131
Effect on the Benefits of This Plan 131
Right to Receive and Release Needed Information 131
Facility of Payment 131
Right of Recovery 132
Effect of Medicare 132
CLAIMS 133
Notice of Claim 133
Services from Network Providers 133
Services from Non-Network Providers 134
Emergency Services from Non-Network Providers 134
Cooperation Provision 135
Claims Incurred for Emergency Services While Traveling Outside the United States 135
Custodial Parent 136
Right to Receive and Release Necessary Information and Medical Records 136
Non-Assignment 137
No Third-Party Beneficiaries 137

GRIEVANCE AND APPEAL PROCESS....138
Grievance Process....138
Appeal Process....140
Expedited Internal Appeal....141
External Review....143
GENERAL PROVISIONS....145
Confidentiality....145
Entire Contract....145
Notices....145
Compliance with Law....145
Modification of Contract....146
New Technology....146
Nondiscrimination....146
Non-Waiver....146
Personal Health Information (PHI)....146
Rescissions....147
Repayment for Fraud, Misrepresentation or False Information....147
Conformity with Applicable Laws....147
List of Available Disclosures....147

INTRODUCTION

Welcome to **Ambetter from Coordinated Care**! We have prepared this Contract to help explain your coverage. Please refer to this Contract whenever you require medical services. It describes:

1. How to access medical care.
2. The health care services we cover.
3. The portion of your health care costs you will be required to pay.

This Contract, the Schedule of Benefits, the application as submitted to the Exchange or the application as submitted to Ambetter from Coordinated Care (if purchasing a Contract outside the Exchange), and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided or paid for by us.

Because many of the provisions are interrelated, you should read this entire Contract to gain a full understanding of your coverage. Many words used in this Contract have special meanings when used in a health care setting – these words are capitalized and are defined in the **DEFINITIONS** section. This Contract also contains exclusions, so please be sure to read this entire Contract carefully.

How to Contact Us

Ambetter from Coordinated Care
1145 Broadway, Suite 700
Tacoma, WA 98402

Normal Business Hours of Operation 8:00 a.m. to 8:00 p.m. local time, Monday through Friday

Member Services:..... 1-877-687-1197
TTY line: 711
Fax:..... 1-877-941-8078
Substance Use/Mental Health: 1-877-687-1197
24/7 Nurse Advice Line:.... 1-877-687-1197

Other Important Phone Numbers

Vision Benefits:..... 1-877-687-1197
Pharmacy Benefits: 1-877-687-1197
Emergency: 911
Suicide and Crisis Lifeline. 988 (call or text)

Health Plan Managers

At Coordinated Care Corporation, we partner with several organizations to help us administer your health benefits. These organizations are known as Health Care Benefit Managers (HCBMs). They provide services to ensure the health care you receive is a Covered Service or

you have access to Providers in your Network. You can access our list of Health Care Benefit Managers at AmbetterHealth.com/en/WA.

Interpreter Services

Ambetter from Coordinated Care has a free service to help Members who speak languages other than English. These services ensure that you and your Physician can talk about your medical or Behavioral Health concerns in a way that is comfortable for you.

Our interpreter services are provided at no cost to you. We have medical interpreters to assist with languages other than English via phone. An interpreter will not go to a Provider's office with you, except under certain circumstances. Members who are blind or visually impaired and need help with interpretation can call Member Services for oral interpretation, or to request materials in Braille or large font.

To arrange for interpreter services, please call Member Services or for the hard of hearing TTY: 711.

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting you as a Member.
2. Encouraging open discussions between you, your Physician, and other Medical Practitioners.
3. Providing information to help you become an informed health care consumer.
4. Providing access to Covered Services and our Network Providers.
5. Sharing our expectations of you as a Member.
6. Providing coverage regardless of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

These rights and responsibilities are further detailed in the sections throughout this Contract. Please see applicable sections for additional information.

You have the right to:

1. Participate with your Physician and Medical Practitioners in decisions about your health care. This includes working on any treatment plans and making care decisions. You should know any possible risks of various treatment options you may have, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally Authorized Representative. Your Provider should inform you of your care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which you have coverage. Coverage requires the use of Network Providers as explained in this document. Failure to utilize Network Providers without Prior Authorization, except for Emergency Services, may result in denial of benefits.
4. Be treated with respect and dignity.
5. Privacy of your personal health information, consistent with state and federal laws, and our policies.
6. Receive information, about our organization and services; our Network of Physicians, Medical Practitioners, Hospitals and other Facilities; changes in Network status for Providers who you are receiving treatment from, our policies, and member rights and responsibilities.
7. Candidly discuss with your Physician and Medical Practitioners appropriate and Medically Necessary care for your condition, including new uses of technology, regardless of cost of such services or whether the services are part of your benefit coverage. This includes information from your Primary Care Provider about what might be wrong (your diagnosis), recommended treatment and other available options, and the most likely results (your prognosis). Your Provider and Member Services can discuss treatments with you that may or may not be covered by the Contract, regardless

of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally Authorized Representative. Your Physician will ask for your approval for treatment unless there is an emergency and your life and health are in serious danger.

8. Voice Complaints or Grievances about our organization, your coverage, or care provided.
9. Appeal any benefit or coverage decisions we (or our designated administrators) make.
10. Refuse treatment to the extent the law allows without jeopardizing future treatment and be informed by your Provider(s) of the medical consequences. You are responsible for your actions if treatment is refused or if the Provider's instructions are not followed. You should discuss all concerns about treatment with your Provider and be informed by your Provider(s) of the medical consequences. Your Provider can discuss different treatment plans with you, if there is more than one option that may help you. You will make the final decision. Your Provider should provide you with information on Advance Directives and you should ask that a copy be kept in your medical chart.
11. See your medical records.
12. You have the right to be informed of covered and non-covered services when you request information or Authorization for services; how to access services; how to choose and/or change your Primary Care Provider assignment; which Providers are Network Providers; how to file an Appeal if you receive a benefit denial; and how to file a Grievance. This includes information on Member rights and responsibilities, and our other rules and guidelines. We will notify you at least 30 calendar days before the Effective Date of any modifications. Any notices will let you know about the effect of any changes on your coverage and any personal liability related to benefits or costs.
13. Select another health plan or switch health plans during open enrollment or a special enrollment period.
14. Adequate access to qualified Physicians and Medical Practitioners and treatment or services regardless of race, color, national origin, age, disability, sex, gender identity or sexual orientation.
15. Access Medically Necessary urgent and Emergency Services 24 hours a day, seven days a week.
16. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
17. Select your Primary Care Provider (PCP) within the Network. You also have the right to change your PCP or request information on Network Providers close to your home or work.
18. Know the name and job title of people providing you care.
19. An interpreter, available by phone, if you do not speak or understand English.
20. A second opinion by a Network Provider, if you want more information about your treatment or would like to explore additional treatment options.

21. Make an Advance Directive for health care decisions. Your Provider should provide you with information on Advance Directives and you should ask that a copy be kept in your medical chart.
22. Determine what actions should be taken regarding your health if you are no longer able to make decisions for yourself because of illness or because you are incapacitated. You have the right to have your wishes known by completing Advance directives forms. Advance Directive forms are forms you can complete to protect your rights for medical care. It can help your Primary Care Provider and other Providers understand your wishes about your health. Advance Directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. Examples of Advance Directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. “Do Not Resuscitate” orders

    Members also have the right to refuse to make Advance Directives. You should not be discriminated against for not having an Advance Directive.
23. Make recommendations regarding our Member rights and responsibilities policy.

You have the responsibility to:

1. Read this entire Contract.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about your health that we or your Medical Practitioners need in order to provide care. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your Physician until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of Covered Services, including the need to use Network Providers and obtain Prior Authorization for services when required.
5. Show your Member identification card and keep scheduled appointments with your Physician, and call the Physician’s office during office hours whenever possible if you have a delay or cancellation.
6. See your assigned Primary Care Provider for most of your care. You may change your Primary Care Provider verbally or in writing by contacting Member Services.
7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and Physician.
9. Tell your health care professional and Physician if you do not understand your treatment plan or what is expected of you. You should work with your Provider to develop

treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.

10. Follow all health benefit plan guidelines, provisions, policies and procedures.
11. Use any emergency room only when you think you have an Emergency Medical Condition. For all other care, you should call your Primary Care Provider or access an Urgent Care Center. You also have access to our 24/7 Nurse Advice Line at 1-877-687-1197 and may be able to access Telemedicine services through your Provider or by calling 1-800-835-2362.
12. Provide us with information about any other health care coverage you obtained before or after enrolling with us. If you enroll in other coverage, you must provide us with the information as soon as possible. This is to avoid improper payments. You cannot enroll in Marketplace Coverage if you already have Medicare coverage. Marketplace Coverage is duplicative for existing Medicare Members and will not provide additional benefits because Medicare is primary.
13. Pay your monthly premiums on time and pay all Deductible Amounts, Copayment Amounts, or Coinsurance percentages.
14. Receive all of your health care services and supplies from Network Providers, except as specifically stated in this Contract.
15. Inform the Washington Health Benefit Exchange or other entity through which you enrolled of any changes to your income, household size, address or health coverage eligibility as soon as possible, but no more than 60 calendar days from the date of the event.
16. Notify us or the Washington Health Benefit Exchange of any enrollment related changes that would affect your Contract within 60 calendar days of the event. Enrollment related changes include the following: birth of a child, adoption, marriage, divorce, change of address, adding/removing a dependent, Spouse/domestic partner becomes eligible under a different insurer, or incarceration where previously satisfied Member Deductible or Out-of-Pocket Maximum amounts within the same calendar year may qualify to transfer from one policy to another policy.

IMPORTANT INFORMATION

Provider Directory

A list of our Network Providers is available online at AmbetterHealth.com/en/WA. Ambetter from Coordinated Care's Provider Network in Washington State is named "CCCWA Exchange." Network Providers listed on the CCCWA Exchange include Physicians, Hospitals, and other Medical Practitioners who have agreed and are contracted to provide our Members with required medical treatment and health care services. You can find our Network Providers by visiting our website and accessing the "Find a Doctor" page. For information about receiving care outside of Washington State, please see the **Service Area** and the **Providers Outside of Washington** provisions in the **ACCESS TO CARE** section.

You may also contact Member Services to request information about whether a Physician, Hospital, or other Medical Practitioner is a Network Provider. We will respond to any such requests within one business day.

If you receive services from a Non-Network Provider because of inaccurate information in the Provider Directory or in response to an inquiry about Network status, please contact Member Services. If the services you received are otherwise Covered Services, subject to Balance Billing Protections as described in the **DEFINITIONS** section of this Contract, you will only be responsible for paying the Cost Sharing that applies to Network Providers and should not be Balance Billed by the Non-Network Provider. See **Balance Billing**, **Balance Billing Protections** and **Non-Network Provider** definitions for additional information. If you are Balance Billed in these situations, please contact Member Services immediately at the number listed on the back of your Member identification card.

You can search for a Provider by name or, if you click on the Type of Provider, you can search for Hospital Providers, Primary Care Providers, Specialist Providers, pharmacies or other Providers. You can also narrow your search by Provider specialty, zip code, gender, languages spoken and whether or not they are accepting new patients. Your search will produce a list of Providers based on your search criteria and includes other information such as name, address, phone number, office hours and specialty and board certifications.

You can request a printed copy of the Provider Directory at no charge by calling Member Services. In order to obtain benefits, you must designate a Primary Care Provider (PCP) for each Member. Otherwise, we will automatically assign a PCP in your area. We can help you pick a PCP if needed. We will make your choice of PCP effective on the next business day, if the selected Physician's caseload permits. We will notify you if your PCP leaves our Network. You will be able to see that PCP for at least 60 calendar days from that notice.

If you have difficulty locating a Primary Care Provider, Specialist Provider, Hospital or other contracted Provider please contact us so we can assist you with access or in locating a contracted Ambetter Provider. Ambetter Physicians may be affiliated with different Hospitals. Our online directory can provide you with information on the Ambetter contracted Hospitals. The online directory also lists affiliations that your Provider may have with non-contracted Hospitals. Your Ambetter coverage requires you to use contracted Providers with limited exceptions.

Call the Provider's office if you want to make an appointment. If you need help, call Member Services.

Member Identification Card

We will mail a Member identification card after we receive your completed enrollment application information and you have paid your initial premium. You need to keep this card with you at all times. Please show this card every time you go for any service under the Contract. The Member identification card will show your name, Member identification number, the phone numbers for Member Services, pharmacy and 24/7 Nurse Advice Line, and Copayment Amounts required at the time of service. Any applicable Deductibles and any applicable out-of-pocket maximum limitations will also be accessible through the Member identification card. If you do not get your Member identification card within a few weeks after you enroll, please call Member Services. We will send you another card. A temporary identification card can be downloaded from AmbetterHealth.com/en/WA.

Website

Our website can answer many of your frequently asked questions and has resources and features that make it easy to get quality care. Our website can be accessed at AmbetterHealth.com/en/WA. It also gives you information on your benefits and services such as:

1. Finding a Network Provider, including Hospitals and pharmacies.
2. A secure portal for you to check the status of your Claims, make payments and obtain a copy of your Member identification card.
3. Our programs and services, including programs to help you get and stay healthy.
4. Member Rights and Responsibilities.
5. Notice of Privacy Practices.
6. Current events and news.
7. Deductible and Copayment accumulators.
8. Our Formulary or Prescription Drug List.
9. Selecting a Primary Care Provider.
10. An online copy of this Evidence of Coverage (EOC).

Quality Improvement

We are committed to providing quality health care for you and your family. Our primary goal is to improve your health and help you with any illness or disability. Our program is consistent with National Committee on Quality Assurance (NCQA) standards and the National Academy of Medicine (NAM) priorities. To help promote safe, reliable, and quality health care, our programs include:

1. Conducting a thorough check on Providers when they become part of the Provider Network.

2. Providing programs and educational items about general health care and specific diseases.
3. Sending reminders to Members to get annual services such as physical examinations, cervical cancer screening, breast cancer screening, and flu shot.
4. A Quality Improvement Committee which includes Network Providers to help us develop and monitor our program activities.
5. Investigating any Member concerns regarding care or services received.

If you have a concern about the care or services you received from your Network Provider or service provided by us, please contact Member Services.

We believe that getting Member input can help make the content and quality of our programs better. We conduct a Member survey, typically on an annual basis, that asks questions about your experience with the health care and services you are receiving.

Protection from Balance Billing

Under the Washington Balance Billing Protection Act, effective January 1, 2020, and amended March 31, 2022, and June 6, 2024, Non-Network Providers or Facilities and Ground Ambulance Services Organizations in Washington State are prohibited from Balance Billing health plan Members for services that are subject to Balance Billing Protections as described in the **DEFINITIONS** section of this Contract. You will only be responsible for paying your Member Cost Share for these services, which is calculated as if you had received the services from a Network Provider and based on the recognized amount as defined in Applicable Law.

DEFINITIONS

Wherever used in this Contract:

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition or psychosocial behavior.

Acute Rehabilitation means Rehabilitation for patients who will benefit from an intensive, multidisciplinary Rehabilitation program. Patients normally receive a combination of therapies such as physical, occupational and speech therapy as needed and are medically managed by specially trained Physicians. Rehabilitation services must be performed for three or more hours per day, five to seven days per week, while the Member is confined as an Inpatient in a Hospital, Rehabilitation Facility, or Extended Care Facility.

Advance Premium Tax Credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to the maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you are due, you will get the difference as refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return. For more information, please contact the Washington Health Benefit Exchange.

Adverse Benefit Determination or **Adverse Determination** means any decision we make that results in a denial, reduction, termination of, or failure to provide or make payment, in whole or in part, for a benefit. This includes determinations:

1. Based on a Member’s or applicant's eligibility to participate in an Ambetter plan, including denial of an application for coverage.
2. That an item or service is Experimental or Investigational, or not Medically Necessary or appropriate.
3. Resulting from the application of any Utilization Review, including eligibility, medical necessity, appropriateness, health care setting, level of care, effectiveness, and Experimental or Investigational determinations.
4. Resulting from a prospective or retrospective review.
5. Resulting from a Claim or Appeal denial.
6. Resulting from a determination that Balance Billing Protections do not apply to a service or Claim.
7. Resulting from an incorrectly calculated amount of Cost Sharing a Member owes when Balance Billing Protections apply.
8. Resulting from a final Claim payment for less than the amount of the Claim submitted. This does not include a Claim that is paid less than the original amount to reflect the contracted health care Provider’s rate.

9. Regarding Rescission of coverage.

Please refer to the **GRIEVANCE AND APPEALS PROCESS** section of this Contract for information about your right to Appeal an Adverse Benefit Determination.

Allowed Amount (also see **Eligible Expense**) means the maximum amount we will pay, including any applicable Member Cost Sharing responsibility, for a Covered Service received from either a Network or Non-Network Provider. When a Covered Service is received from a Network Provider, the Allowed Amount is the amount the Provider agreed to accept from us as payment in full for that particular service. In all cases, the Allowed Amount includes any Cost Sharing owed by the Member (e.g., Deductible, Coinsurance and Copayment).

1. For Network Providers: When a Covered Service is received from a Network Provider, the Allowed Amount is the contracted fee with that Provider.
2. For Non-Network Providers, unless otherwise required by federal or Washington Law, the Allowed Amount is as follows:
    a. When Balance Billing Protections apply to a Covered Service received from a Non-Network Provider, the Eligible Expense is the negotiated fee, if any, that has been mutually agreed upon by us and the Provider as payment in full. If the Provider has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by Applicable Law, the Allowed Amount is reimbursement as determined by us and as required by Applicable Law.
    b. When Balance Billing Protections apply to a Covered Service received from a Non-Network Ground Ambulance Services Organization, the Eligible Expense is one of the following amounts until December 31, 2027:
        i. The rate established by the local government entity where the Covered Service originated for the provision of ground ambulance services by Ground Ambulance Services Organizations owned and operated by the local governmental entity and submitted to the Office of the Insurance Commissioner (OIC);
        ii. Where the ground ambulance service was provided by a private Ground Ambulance Services Organization under contract with the local governmental entity where the Covered Service originated, the amount set by the contract and submitted to the OIC; or
        iii. If a rate has not been established or contracted as described above, the rate will be the lesser of:
            a) 325 percent of the current published rate for ambulance services as established by the Centers for Medicare and Medicaid Services (CMS)
            b) The Ground Ambulance Services Organization’s billed charges.
    c. For all other Covered Services received from a Non-Network Provider for which any needed Authorization is received from us, the Eligible Expense is the negotiated fee, if any, that has been mutually agreed upon by us and the Provider as payment in full (you will not be billed for the difference between the negotiated fee and the Provider’s charge). If there is no negotiated fee agreed to by the Provider with us, the Allowed Amount is reimbursement as determined by

us and as required by Applicable Law. In addition to applicable Cost Sharing, you may be Balanced Billed for these services.

d. Services received from a Non-Network Provider without Authorization and not subject to Balance Billing Protections are not covered. The Provider will bill you for these services.

Note: If you receive services from a Non-Network Provider, you may be responsible for the difference between the amount the Provider charges for the service (Billed Amount) and the Allowed Amount that we pay. However, you will not be responsible for Balance Billing for non-network care that is subject to Balance Billing Protections and otherwise covered under your Contract. See **Balance Billing**, **Balance Billing Protections** and **Non-Network Provider** definitions for additional information. If you are Balanced Billed in these situations, please contact Member Services immediately to request an Appeal at the number listed on the back of your Member identification card.

Ambetter-designated Telehealth Provider means the vendor selected by Ambetter to contract with Providers or any Network Provider to render telehealth services, including Virtual 24/7 Care benefits, to Members. All services provided through the Ambetter-designated Telehealth Provider shall be deemed independent from Ambetter to ensure that a Member's care and treatment plan are rendered via a practicing Physician, or other medical professional with appropriate licensure.

Ambulatory Surgery Center or **Ambulatory Surgical Center** means a Facility, licensed by the state in which it is located, that is equipped and operated mainly for Surgeries or obstetrical deliveries that allow patients to leave the Facility the same day the Surgery or delivery occurs.

Appeal means a written or verbal request from a Member or the Member's Authorized Representative, that we reconsider an Adverse Benefit Determination or decision we made regarding:

1. Access to health care benefits;
2. Admission to or continued stay in a health care Facility;
3. Claims payment, handling or reimbursement for health care services;
4. Matters pertaining to our contractual relationship with a Member;
5. Cancellation of your benefit coverage by us; and
6. Any matters specifically required by state law or regulation.

Please refer to the **GRIEVANCE AND APPEALS PROCESS** section of this Contract for detailed information about your Appeal rights, including how to file an Appeal and who may file an Appeal on your behalf.

Applicable Laws mean Washington state laws and/or federal laws.

Applied Behavior Analysis (**ABA**) is the application of behavioral principles to everyday situations, intended to increase or decrease targeted behaviors. ABA has been used to improve areas such as language, self-help, and play skills, as well as decrease behaviors such as aggression, self-stimulatory behaviors and self-injury.

Attending Physician means the Physician responsible for the care of a patient and/or the Physician supervising the care of patients by residents, and/or medical students.

Authorization or **Authorized** means our decision to approve the medical necessity or the appropriateness of care for a Member requested by the Member's PCP or Provider group before the Member receives services.

Authorized Representative means an individual who represents a Member in an internal Appeal or External Review process of an Adverse Benefit Determination who is any of the following:

1. A person to whom a covered individual has given express, written consent to represent that individual in an internal Appeals process or External Review process of an Adverse Benefit Determination;
2. A person authorized by law to provide substituted consent for a covered individual; or
3. A family member or a treating Medical Practitioner, but only when the Member is unable to provide consent.

Autism Spectrum Disorder means a neurological and developmental disorder, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or the most recent edition of the International Classification of Diseases that begins early in childhood and lasts throughout a person's life. It is a condition related to brain development that impacts how a person perceives and socializes with others, causing problems in social interaction and communication. It may include intellectual impairment but not always. The disorder may include problems with the ability to recognize or share interests or emotional experiences, problems expressing or understanding verbal or non-verbal communication, and/or developing or maintaining relationships. Repetitive patterns of behavior or an inability to tolerate change is often seen.

Balance Billing means a Non-Network Provider bills a Member for health care services provided to the Member after the Provider or Facility's Billed Amount is not fully reimbursed by the health plan, exclusive of permitted Cost Sharing.

Balance Billing Protections mean the protections against Balance Billing under the federal No Surprises Act or Washington State Balance Billing Protection Act (BBPA). These protections apply to Covered Services that are:

1. Emergency Services provided to a Member, as well as services provided after the Member is Stabilized;
2. Non-emergency health care services provided to a Member at a Network Hospital or at a Network Ambulatory Surgical Center unless if Member gave Notice and Consent pursuant to the federal No Surprises Act to be Balance Billed by the Non-Network Provider; or
3. Air or ground ambulance services provided to a Member by a Non-Network Provider.

You will only be responsible for paying your Member Cost Share for these services, which is calculated as if you had received the services from a Network Provider and is based on the recognized amount as defined in Applicable Law. If you are Balance Billed for any of the above services, contact Member Services immediately at the number listed on the back of your Member identification card.

Balance Billing Protection Act (**BBPA**) means a Washington State law that protects the Member from Balance Billing when receiving Emergency Services in the state of Washington from Non-Network Providers and Ground Ambulance Services Organization. In addition, the Member may not be Balanced Billed for services rendered by Non-Network Providers at Network Hospitals and Ambulatory Surgical Centers as described on the consumer disclosure form "Your Rights and Protections Against Surprise Medical Bills and Balance Billing In Washington State." The BBPA's protections are in addition to those afforded by the federal No Surprises Act.

Behavioral Health means both mental health and Substance Use Disorders, encompassing a continuum of prevention, intervention, treatment and recovery support services.

Behavioral Health Emergency Services Provider means Emergency Services provided in the following settings:

1. A crisis stabilization unit as defined in RCW 71.05.020;
2. An evaluation and treatment Facility that can provide directly or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate Inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the Department of Health;
3. An agency certified by the department of health under chapter 71.24 RCW to provide outpatient crisis services;
4. A triage facility as defined in RCW 71.05.020;
5. An agency certified by the department of health under chapter 71.24 RCW to provide medically managed or medically monitored withdrawal management services; or
6. A mobile rapid response crisis team as defined in RCW 71.24.025 that is contracted with a Behavioral Health administrative services organization operating under RCW 71.24.045 to provide crisis response services in the Behavioral Health administrative services organization's Service Area.

Behavioral Health Practitioner means as related to Mental Health Disorder/Substance Use Disorder services, refers to a mental health or Substance Use Disorder Provider licensed/certified by the state in which care is being rendered and performing services within the scope of that license/certification.

Bereavement Counseling means counseling of Members of a deceased person's Immediate Family that is designed to aid them in adjusting to the person's death.

Billed Amount means the amount a Provider charges for a service.

Brand Name Drug or **Brand Name Medication** means a medication sold by a pharmaceutical company under a trademark-protected name. Brand Name Medications can only be produced and sold by the company that holds the patent for the drug.

Care Management means a program in which a registered nurse or licensed mental health professional, known as a care manager, assists a Member through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and health care benefits available to a Member. Care Management is instituted when mutually agreed to by us, the Member and the Member's Provider.

Center of Excellence means a Hospital that:

1. Specializes in a specific type or types of Medically Necessary transplants or other services; and
2. Has agreed with us or an entity designated by us to meet quality of care criteria on a cost-efficient basis is designated as a Center of Excellence on the Provider Directory. The fact that a Hospital is a Network Provider does not mean it is a Center of Excellence.

Chiropractic Care means the involvement of neuromuscular treatment in the form of manipulation and adjustment of the tissues of the body, particularly of the spinal column and may include physical medicine modalities or use of Durable Medical Equipment.

Claim means a request by a Provider to be compensated by us for services provided to a Member. Typically, the Provider will submit a Claim to us; however, if you see a Non-Network Provider, you may need to send us the Claim. Approval and payment of Claims is subject to the Member's benefits, eligibility, and Cost Sharing. See additional information in the **CLAIMS** section of this Contract.

Coinsurance or **Coinsurance Amount** means the part of Covered Service expenses that you are required to pay when you receive a Covered Service. Coinsurance Amounts are listed in the Schedule of Benefits. Not all Covered Services have Coinsurance Amounts.

Complaint means any expression of dissatisfaction by you or your Authorized Representative to us that is about us or Providers with whom we have a direct or indirect contract.

Complications of Pregnancy means:

1. Conditions whose diagnoses are distinct from Pregnancy, but are adversely affected by Pregnancy or are caused by Pregnancy and not, from a medical viewpoint, associated with a normal Pregnancy. This includes, but is not limited to fetal distress, gestational diabetes, toxemia, ectopic Pregnancy, spontaneous abortion, preeclampsia, eclampsia, missed abortion, false labor, edema, morning sickness and similar medical and Surgical conditions of comparable severity.
2. An emergency cesarean section or a non-elective cesarean section.

Contract means this Evidence of Coverage, the enrollment application and Schedule of Benefits, as issued and delivered to you.

Continuing Care Patient means an individual who, with respect to a Provider or Facility:

1. Is undergoing a treatment for a Serious and Complex Condition from that Provider or Facility;
2. Is undergoing a course of institutional or Inpatient care from that Provider or Facility;
3. Is scheduled to undergo non-elective Surgery from that Provider, including postoperative care;
4. Is pregnant and undergoing a course of treatment for the Pregnancy; or
5. Is or was determined to be Terminally Ill and is receiving treatment for such Illness.

Copay, **Copayment** or **Copayment Amount** means the specific dollar amount that you must pay when you receive Covered Services. Copayment Amounts are shown in the Schedule of Benefits. Not all Covered Services have a Copayment Amount.

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

Cost Share or **Cost Sharing** means the part of the costs you are responsible to pay for your insurance coverage, including the Deductible Amount, Copayment Amount and Coinsurance Amount that you pay for Covered Services listed in the Schedule of Benefits. Cost Sharing does not include premiums, Balance Billing amounts for Non-Network Providers or the cost of non-covered services.

Cost Sharing Reductions means the reduction in the amount you have to pay in Deductible Amounts, Copayment Amounts and Coinsurance Amounts. To qualify for Cost Sharing Reductions, an eligible individual must enroll in a silver level plan through the Exchange. Members of a federally recognized American Indian tribe and/or an Alaska Native may qualify for additional Cost Sharing Reductions.

Covered Service(s) means health care services, supplies or treatment described in this Contract that are performed, prescribed, directed or Authorized by a Physician or Medical Practitioner, and are:

1. Provided or incurred while the Member's coverage is effective under this Contract;
2. Covered by a specific benefit provision of this Contract; and
3. Not excluded anywhere in this Contract.

Custodial Care means treatment designed to assist a Member with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial Care includes but is not limited to the following:

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

Deductible or **Deductible Amount** means the amount that you must pay in a calendar year for covered expenses before we will pay benefits. For family coverage, there is a family Deductible which is two times the individual Deductible. Both the individual and the family Deductibles are shown in the Schedule of Benefits.

1. If you are a covered Member in a family of two or more Members, you will satisfy your Deductible when:

2. You satisfy your individual Deductible; or
3. Your family satisfies the family Deductible for the calendar year.

If you satisfy your individual Deductible, each of the other Members of your family are still responsible for their Deductible until the family Deductible is satisfied for the calendar year.

Dental Services means Surgery or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances. Expenses for such treatment are considered Dental Services regardless of the reason for the services.

Dependent Member means the primary Subscriber's lawful Spouse, state registered domestic partner as required by Washington law, and/or an Eligible Child. Each Dependent Member must either be named in the enrollment application or we must agree in writing to add them as a Dependent Member.

Distant Site means the site at which a Physician or other licensed Provider, delivering a professional service, is physically located at the time the service is provided through Telemedicine.

Drug Discount, Coupon or Copayment Card means cards or coupons typically provided by a drug manufacturer to discount the Copayment Amount or your other Out-of-Pocket Expenses (e.g., Deductible Amount or Maximum Out-of-Pocket Amount).

Durable Medical Equipment means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an illness or injury, can withstand repeated use, are generally not useful to a person in the absence of illness or injury, and are appropriate for use in the patient's home. It shall also include sales tax under any benefit for Durable Medical Equipment that is a Covered Service and when equipment is not tax exempt.

Effective Date means the date a Member becomes covered under this Contract for Covered Services. The applicable Effective Date is:

1. The same date as your initial coverage date; or the earliest of the following:
2. The date we approve the addition of any new Member; or
3. The date of birth in the case of a newborn child properly enrolled in coverage; or
4. The date a child is placed in the home for purposes of adoption when properly enrolled in coverage.

Eligible Child means the child of a primary Subscriber, if that child is less than 26 years of age. If an Eligible Child turns 26 during the plan year, they remain an Eligible Child through the end of the plan year. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A child for whom you have assumed a legal obligation for total or partial support in anticipation of adoption;
4. A stepchild for whom the Member has a qualified court order to provide coverage; or
5. A child for whom legal guardianship has been awarded to you or your Spouse.

It is your responsibility to notify the Exchange or us if your child ceases to be an Eligible Child. You must reimburse us for any benefits that we provide or pay for a child at a time when the child did not qualify as an Eligible Child.

A Member will not cease to be a dependent Eligible Child solely beyond the 26th birthday if the Eligible Child is and continues to be both:

1. Incapable of self-sustaining employment by reason of developmental or physical disability, and;
2. Chiefly dependent on the primary Member for support and maintenance.

Eligible Expense (see **Allowed Amount** definition).

Emergency Medical Condition means a medical condition or a Behavioral Health condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain or emotional distress) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical or Behavioral Health attention to result in the following:

1. Placing the physical health or Behavioral Health of the Member, (or, with respect to a pregnant Member, the health of the Member or the Member's unborn child) in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part.

Emergency Services means Covered Services needed to evaluate and Stabilize an Emergency Medical Condition. This includes a medical screening examination in a Hospital emergency department (including labor and delivery departments) or independent freestanding emergency department to evaluate the Emergency Medical Condition, as well as services needed to Stabilize the Emergency Medical Condition. Services to Stabilize an Emergency Medical Condition can be provided in any department of a Hospital.

Emergency Services for Behavioral Health means a screening examination that is within the capability of a Behavioral Health Emergency Services Provider including Ancillary Services routinely available to the Behavioral Health Emergency Services Provider to evaluate the Emergency Medical Condition.

1. Examination and treatment, to the extent they are within the capabilities of the staff and Facilities available at the Behavioral Health Emergency Services Provider, as are required under section 1867 of the Social Security Act (42 U.S.C. Sec. 1395dd) or as would be required under such section if such section applied to Behavioral Health Emergency Services Providers, to Stabilize the patient. Stabilize, with respect to an Emergency Medical Condition, has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. Sec. 1395dd(e)(3));
2. Covered Behavioral Health services provided by staff or Facilities of a Behavioral Health Emergency Services Provider after the Member is Stabilized and as part of outpatient observation or an Inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished. Post-Stabilization Services relate to mental health or Substance Use Disorder treatment necessary in the short term to avoid placing the health of the individual, or with respect to a pregnant Member,

the health of the Member or the Member's unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Established Relationship means the Provider providing audio-only Telemedicine has access to sufficient health records to ensure safe, effective and appropriate care services and (i) the Member has had within the past three years at least one in-person appointment or at least one-real-time interactive appointment using both audio and video technology with the Provider providing audio-only Telemedicine or with a Provider employed at the same medical group, at the clinic, as the Provider providing audio-only Telemedicine or (ii) the Member was referred to the Provider providing audio-only Telemedicine by another Provider who has had within the past three years, at least one in-person appointment or at least one real-time interactive appointment using both audio and video technology with the Member and has provided relevant medical information to the Provider provided audio-only technology.

Exchange means the Washington Health Benefit Exchange established under chapter 43.71 of the Revised Code of Washington (RCW). This is the online marketplace to purchase health insurance coverage in Washington.

Expedited Appeal means a request for expedited review and determination of an Appeal. You or your Provider may file an Expedited Appeal if:

1. You are currently receiving or are prescribed treatment or benefits, including Prescription Drugs, for a medical condition, that will end because of our Adverse Benefit Determination; or
2. Your treating Provider believes that a delay in treatment based on the application of standard Appeal timeframes for a pre-service or concurrent care could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject you to severe and intolerable pain; or
3. The Appeal concerns an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged from the emergency room or transport service.

Experimental or Investigational means that a service is considered Experimental or Investigational for a Member's condition if any of the following statements apply to it at the time the service is or will be provided to the Member:

1. The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has not been granted.
2. The service is the subject of a current new drug or new device application on file with the FDA.
3. The service is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity or effectiveness of the service.
4. The service is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy as among its objectives.
5. The service is under continued scientific testing and research concerning the safety, toxicity or effectiveness of services.

6. The service is provided pursuant to informed consent documents that describe the service as Experimental or Investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity or efficacy.
7. The prevailing opinion among experts, as expressed in the published authoritative medical or scientific literature, is that:
    a. the use of such service should be substantially confined to research settings, or
    b. further research is necessary to determine the safety, toxicity or efficacy of the service.

In determining whether services are Experimental or Investigational, we will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.

The following sources of information will be exclusively relied upon to determine whether a service is Experimental or Investigational. This information will be made available for inspection upon the written request of the Member and will not be withheld as proprietary:

1. The Member's medical records,
2. The written protocol(s) or other document(s) pursuant to which the service has been or will be provided,
3. Any consent document(s) the Member or Member's representative has executed or will be asked to execute, to receive the service,
4. The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
5. The published authoritative medical or scientific literature regarding the service, as applied to the Member's illness or injury, and
6. Regulations, records, applications and any other documents or actions issued by, filed with or taken by, the FDA or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

Appeals regarding any denial of coverage based on a service being Experimental or Investigational can be submitted to Member Services at 1145, Suite 700, Tacoma, WA 98402.

Extended Care Facility (**ECF**) means a Facility that is primarily engaged in providing comprehensive post-acute Hospital and Inpatient rehabilitative care and is licensed by the designated government agency to provide such services. The definition of an ECF does not include institutions that provide only minimal custodial, assisted living, independent living communities, extended nursing homes, residential care homes, ambulatory or part-time care services or institutions that primarily provide for the care and treatment of Behavioral Health or pulmonary tuberculosis.

External Review means review of a health plan decision to deny coverage or payment for a service, including Prescription Drugs, by a third-party Independent Review Organization (IRO)

not related to the plan. External Review by an IRO can be requested after we deny an internal Appeal, and in urgent situations can be requested even if the internal Appeals process is not yet completed. External Review is available whenever we make an Adverse Benefit Determination including a determination of whether Balance Billing Protections apply and the Member Cost Sharing that applies for services subject to Balance Billing Protections (see definition above). The IRO performing the review will either uphold our decision or overturn all or some of the decision. We must accept the IRO's decision as binding unless other remedies are available under state or federal law.

Facility means an institution categorized as a Hospital, an outpatient clinic, Hospice, an Extended Care Facility, an Urgent Care Center, an Ambulatory Surgical Center, a Skilled Nursing Facility, a Residential Treatment Facility, an Inpatient Facility or a federally Qualified Health Center.

Facility Fee means a charge incurred to the Member for Covered Services rendered by a Network Provider in a Facility.

Formulary or **Prescription Drug List** means our list of covered drugs. It is available on our website at AmbetterHealth.com/en/WA or by calling Member Services.

Gender Affirming Treatment means services for the Medically Necessary Gender Affirming Treatment including facial feminization and other surgeries or treatment to support transition due to gender dysphoria, if such services are prescribed in accordance with accepted standards of care.

Generally Accepted Standards of Medical Practice means 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.

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. We reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is Medically Necessary and is a Covered Service under the Contract. The decision to apply Physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by us.

Generic Drugs, also known as therapeutic equivalent medications, means Prescription Drugs/medication that contain the same active ingredient(s), have the same dosage form (e.g., they are both tablets), have the same route of administration (e.g., they are both taken by mouth), and are identical in strength. These drugs may differ in shape, look (markings on the tablets or capsules), and inactive ingredients (such as color, flavor, and preservatives). Medications classified as therapeutic equivalents can be substituted for each other with the full expectation that both medications will produce the same effect and have the same level of safety.

Grievance means a written or oral Complaint submitted by or on behalf of a Member regarding service delivery issues other than denial of payment for medical services or non-provision of medical services, including:

1. Dissatisfaction with medical care;
2. Waiting time for medical services;

3. Provider or staff attitude or demeanor; or
4. Dissatisfaction with service provided by us.

Ground Ambulance Services Organization means a public or private organization licensed by the Department of Health under chapter 18.73 of the Revised Code of Washington (RCW) to provide ground ambulance services.

Habilitation or **Habilitation Services** means health care services that help a patient keep, learn or improve skills and functioning for daily living. These services may be performed in an Inpatient or outpatient setting and include: physical therapy, occupational therapy and speech therapy.

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

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

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

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

1. Operates pursuant to law as a Home Health Care Agency;
2. Is regularly engaged in providing Home Health Care under the regular supervision of a registered nurse;
3. Maintains a daily medical record on each patient; and
4. Provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing Generally Accepted Standards of Medical Practice for the injury or illness requiring the Home Health Care.

An agency that is approved to provide Home Health Care to those receiving Medicare benefits will be deemed to be a Home Health Care Agency.

Hospice means services designed for and provided to Members who are diagnosed with a terminal condition and are in a Hospice Inpatient program or in a home setting, as certified by a Network Physician. Their purpose is to minimize patient discomfort and address the special physical, psychological, and social needs of a Terminally Ill Member and their Immediate Family. A Member may be transferred to a Hospice program, licensed by the state, if necessary, as determined by a Network Physician.

Hospital means an institution that:

1. Operates as a Hospital pursuant to law;
2. Operates primarily for the reception, care, and treatment of sick or injured persons as Inpatients;
3. Provides 24-hour nursing service by registered nurses on duty or call;
4. Has staff of one or more Physicians available at all times;

5. Provides organized Facilities and equipment for diagnosis and treatment of acute medical, Surgical, or mental conditions either on its premises or in Facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care Facility; an Extended Care Facility, nursing, rest, Custodial Care, or convalescent home; a halfway house, transitional Facility, or Residential Treatment Facility; a place for the aged, drug addicts, alcoholics, or runaways; a Facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable Hospital unit, section, or ward used primarily as a nursing, rest, Custodial Care or convalescent home, Rehabilitation Facility, Extended Care Facility, or Residential Treatment Facility, halfway house, or transitional Facility, or a patient is moved from the emergency room in a short-term observation status, a Member will not be considered in a Hospital for purposes of this Contract.

Hospital Based Provider means a Provider who provides services chiefly within a Hospital, for example, anesthesiologists, emergency department Physicians, pathologies and radiologists. Please see additional information in the **ACCESS TO CARE** section.

Immediate Family means the parents, Spouse, Eligible Child (by blood, adoption, marriage or state registered domestic partnership), or siblings of any Member.

Independent Review Organization (**IRO**) means an independent Physician review organization which acts as the decision-maker when External Review of a decision or internal Appeal outcome is requested. A given IRO is assigned to us via state regulatory requirements and acts as an independent contractor. The IRO is an impartial reviewer and we have no control over its decision.

Inpatient means that services, supplies or treatment, for a medical condition or a Behavioral Health condition are received by a person who is an overnight resident patient of a Hospital or other Facility, using and being charged for room and board.

Intensive Care Unit means a unit or area of a Hospital that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

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

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

Maximum Out-of-Pocket Amount means the maximum amount a Member must pay towards Covered Services in the form of Cost Sharing in a given plan year. A Member’s Deductible, Prescription Drug Deductible (if applicable), Copayment Amount, and Coinsurance Amount all contribute towards the Maximum Out-of-Pocket Amount. The individual and family Maximum Out-of-Pocket Amounts are shown in your Schedule of Benefits.

Maximum Therapeutic Benefit means the point in the course of treatment where no further improvement in a Member's medical condition can be expected, even though there may be fluctuations in levels of pain and function.

Medical Practitioner includes but is not limited to: a Physician, nurse anesthetist, physician assistant, physical therapist, certified nurse midwives, dentists (Doctor of Medical Dentistry or

Doctor of Dental Surgery, or a denturist), chiropractors, podiatrists, nurses, social workers, optometrists, and psychologists. Services are permitted by every category of health care Provider licensed or certified to practice in accordance with Title 18 Revised Code of Washington and engaged in the delivery of services permitted by their scope of practice.

Medically Necessary means appropriate and clinically necessary health care services, items, or supplies which are provided to a Member for the diagnosis, care or treatment of an illness or injury and which meet all of the standards set forth below:

1. Are not solely for the convenience of the Member, the Member's family or the Provider of the services or supplies;
2. Are the most appropriate level of service or supply which can be safely provided to the Member;
3. Are for the diagnosis or treatment of an actual or existing illness or injury unless being provided under the Preventive Care Benefits;
4. Are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions;
5. Are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the Member's condition or the quality of health services rendered;
6. As to Inpatient care, could not have been provided in a Provider's office, the outpatient department of a Hospital or a non-residential Facility without affecting the Member's condition or quality of health services rendered;
7. Are not primarily for research and data accumulation; and
8. Are not Experimental or Investigational.

The fact that a Physician may prescribe, refer, or direct a service does not mean the service is Medically Necessary, Authorized or covered under this Contract. Medical necessity criteria for Covered Services will be furnished to a Member or Provider within 30 calendar days of a request to do so.

Medical necessity determinations will be made in a timely manner by thorough review from Ambetter from Coordinated Care clinical staff. Determinations will be made utilizing guideline based care, appropriate utilization management policies, and by applying clinical judgment and experience. Medical policies are developed through periodic review of Generally Accepted Standards of Medical Practice and updated at least on an annual basis. Current medical policies are available on our website.

Charges incurred for treatment not Medically Necessary are not Eligible Expenses.

In the event that a Member may not agree with the medical necessity determination, a Member has the opportunity to Appeal the decision. Please refer to the "**GRIEVANCE AND APPEAL PROCESS**" section of the Contract for information about filing an Appeal.

Member means an individual covered by the health plan including an enrollee, Subscriber or Contract holder.

Mental Health Disorder means a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases.

Minimum Essential Coverage means any health insurance plan that meets the Affordable Care Act (ACA) requirement(s) for health insurance coverage. Examples include, job-based plans, Health Insurance Marketplace (Marketplace) plans, most individual plans sold outside of the Marketplace, Medicare, Medicaid, Children Health Insurance Program (CHIP), TRICARE, COBRA and plans sold through the Small Business Health Insurance Program (SHOP) Marketplace.

Necessary Medical Supplies mean medical supplies that are:

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

Necessary Medical Supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

Network means a group of Providers or Facilities (including, but not limited to Hospitals, Inpatient mental health care facilities, medical clinics, Behavioral Health clinics, acupuncturists, chiropractors, massage therapists, nurse practitioners, addiction medicine practitioners, etc.) who have contracts with us, or our contractor or subcontractor, and have agreed to provide health care services to our Members for an agreed upon fee. Members will receive most if not all of their health care services by accessing the Network. Ambetter from Coordinated Care's Network name is CCCWA Exchange.

Network Eligible Service(s) means Covered Service(s) that are provided by a Network Provider, or a service that has been Authorized at a Network Facility. Network Eligible Service(s) includes benefits for Emergency Services even if provided by a Non-Network Provider.

Network Provider means any licensed Medical Practitioner or entity that has entered into a Contract directly or indirectly with Ambetter from Coordinated Care to provide a Covered Service to Members enrolled under this Contract including but not limited to Hospitals, specialty Hospitals, Urgent Care Facilities, Physicians, pharmacies, laboratories and other health professionals.

No Surprises Act means a federal law effective on January 1, 2022, that in conjunction with the Balance Billing Protection Act (BBPA) protects the Member from Balance Billing when receiving Emergency Services in the state of Washington from Non-Network Providers and air or ground ambulance services for an Emergency Medical Condition. In addition, the Member may not be Balanced Billed for services rendered by Non-Network Providers at Network Hospitals and Ambulatory Surgical Centers. Members are also protected from Balance Billing for Emergency Services and air ambulance services when received from out-of-state and Non-Network Providers.

Non-Network Provider, sometimes referred to as an "out-of-network Provider," means a Medical Practitioner, Behavioral Health Practitioner or Facility who is not contracted with us or

our contractor or subcontractor. Services received from a Non-Network Provider or Facility are not covered, except for:

1. Emergency Services, as described in the **COVERED SERVICES** section of this Contract;
2. Non-emergency health care services received at a Network Hospital or a Network Ambulatory Surgical Center, as described in the **ACCESS TO CARE** section of this Contract;
3. Air or ground ambulance services, as described in the **COVERED SERVICES** section of this Contract; and
4. Situations otherwise specifically described in this Contract.

Notice and Consent means, with respect to any services where the federal No Surprises Act applies, the conditions that must be met in order for a Member to waive Balance Billing Protections as permitted by the federal No Surprises Act outside of Washington state. Notice and Consent occurs only when each of the following conditions is met:

1. The Non-Network Provider provides the Member a written notice in the format required by Applicable Law that states the provider is a Non-Network Provider, includes a good-faith estimate of the Non-Network Provider's charges for the services, identifies any Prior Authorization or other limitations that may be required in advance of receiving the services, and clearly states that consent is optional and the Member may seek care from a Network Provider.
2. The Non-Network Provider provides the notice described above to the Member at least 72 hours before the services are furnished, except that for services scheduled within 72 hours, the notice must be provided at least three hours before the services are furnished.
3. The Member provides written consent to be treated by the Non-Network Provider that includes the following:
    a. The Member's acknowledgement that they have been provided written notice as described above and informed that payment of the Non-Network Provider's Billed Amount may not accrue toward the Member's Deductible or Maximum Out-of-Pocket Amount;
    b. The Member's statement that by signing the consent, they agree to be treated by the Non-Network Provider and understand they may be Balance Billed and subject to Cost Sharing that applies to Non-Network Providers; and
    c. The time and date on which the Member received the written notice and signed the consent to receive services from the Non-Network Provider.
4. The Member's consent is provided voluntarily, obtained by the Non-Network Provider in the format required by Applicable Law, and not revoked by the Member before the services are provided.
5. The Non-Network Provider provides the Member the notice document and the consent document together, but physically separate from other documents.

6. The Non-Network Provider provides the Member a copy of the signed written Notice and Consent through email or mail.

Notice and Consent will not waive Balance Billing Protections for Emergency Services, air and/or ground ambulance services, services furnished due to unforeseen and urgent medical needs, services provided by a Non-Network Provider when there is no Network Provider available at the Facility, or Ancillary Services (which are services related to emergency medicine, anesthesiology, pathology, radiology and neonatology; diagnostic services such as radiology and laboratory services; and services provided by non-physician practitioners, assistant surgeons, hospitalists, and intensivists).

Originating Site means the physical location of a patient receiving health care services through Telemedicine.

Orthotic Device means a Medically Necessary device used to support, align, prevent or correct deformities, protect a body function, improve the function and moveable body part or assist with dysfunctional joints. Orthotics must be used for therapeutic support, protection, restoration or function of an impaired body part for treatment of an illness or injury.

Out-of-Pocket Expenses mean those Cost Sharing amounts paid by a Member for Covered Services that are applied to the Maximum Out-of-Pocket Amount.

Outpatient Services means Facility, ancillary and professional charges when given as an Outpatient at a Hospital, alternative care Facility, retail health clinic or other Provider as determined by us. These Facilities may include a non-hospital site providing diagnostic and therapy services, Surgery, Rehabilitation or other Provider Facility as determined by us. Professional charges only include services billed by a Provider.

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

Physician means a licensed Medical Practitioner who is practicing within the scope of their licensed authority in treating a bodily injury or illness and is required to be covered by state law. A Physician does not include someone who is related to a Member by blood, marriage or adoption.

Post-Stabilization Services means services furnished after a Member's Emergency Medical Condition is Stabilized and as part of outpatient observation or Inpatient or Outpatient Services with respect to the visit in which other Emergency Services are furnished.

Pregnancy means the physical condition of being pregnant but does not include Complications of Pregnancy.

Prescription Drug means any FDA-approved medicinal substance whose label is required to bear the legend "RX only." They are drugs that have been approved by the FDA and which can, under federal or state law, be dispensed only with a prescription.

Prescription Drug Deductible Amount means the amount of covered expenses, shown in the Schedule of Benefits, if applicable, that must actually be paid during any calendar year before any Prescription Drug benefits are payable.

Preventive Care Benefits means services or measures taken to promote health and early detection or prevention of diseases and Injuries, rather than treating or curing them. Preventive care includes, but is not limited to, immunizations, medications, tobacco cessation treatment, examinations and screening tests tailored to an individual's age, health and family history. For more details, see the **Preventive Care Benefits** provision in the **COVERED SERVICES** section.

Primary Care Provider or **PCP** means a Medical Practitioner who gives or directs health care services for the Member. Primary Care Providers include but are not limited to family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), physician assistants (PA), pediatricians, obstetricians and/or gynecologists (OB/GYN) and internists or any other practice allowed by the plan. A PCP supervises, directs and gives initial care and basic medical services to the Member and is in charge of the Member's ongoing care. Hospital based Primary Care Providers (those practicing on a Hospital campus or co-located within a Hospital) may charge a Facility Fee in addition to any charges for Covered Services. Facility Fees are payable by you and will be applied to your Deductible.

Prior Authorization means a process of obtaining Ambetter's Authorization for certain services before a Member receives them. Prior Authorization is our approval that a requested health care service, treatment plan, Prescription Drug or Durable Medical Equipment is Medically Necessary. Authorized Covered Services shall not exceed the limits of the approved Authorization and are subject to eligibility and all other terms, conditions, limitations and exclusions of this Contract. Please refer to the **PRIOR AUTHORIZATION** section of this Contract for further information.

Prosthetic Device means a Medically Necessary device used to replace, correct or support a missing portion of the body, to prevent or correct a physical deformity or malfunction, or to support a weak or deformed portion of the body.

Provider (see **Network Provider** and **Non-Network Provider** definitions).

Qualified Health Plan or **QHP** means a health plan that has in effect a certification granted by the Washington Health Benefits Exchange and has been approved by the Washington State Office of the Insurance Commissioner.

Qualified Individual means, with respect to the Exchange, an individual who has been determined eligible to enroll through the Exchange in a Qualified Health Plan in the individual market.

Reconstructive Surgery means Surgery performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible.

Rehabilitation means the Medically Necessary services that help a person keep, restore or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt or disabled. This type of care includes Acute Rehabilitation, Sub-Acute Rehabilitation, or Intensive Day Rehabilitation, and it includes Rehabilitation Therapy and Pain Management Programs. An Inpatient hospitalization will be deemed to be for Rehabilitation at

the time the patient has been Stabilized and begins to receive Rehabilitation Therapy or treatment under a Pain Management Program.

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

1. Is licensed as a Rehabilitation Facility; and
2. Operates primarily to provide 24-hour primary care or Rehabilitation of sick or injured persons as Inpatients.

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

Rehabilitation Licensed Practitioner means, but is not limited to, a Physician, physical therapist, massage therapist, speech therapist, occupational therapist, or respiratory therapist. A Rehabilitation Licensed Practitioner must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation Therapy means therapy to help a person regain abilities that have been lost or impaired as a result of disease, injury or treatment. It is provided to optimize functioning and reduce disability in individuals. Types of Rehabilitation Therapy include physical therapy (including massage therapy), occupational therapy, speech therapy, cardiac therapy, aural therapy, pulmonary therapy and respiratory therapy. It may occur in either an outpatient or Inpatient setting.

Rescission means a determination by us to withdraw the coverage back to the initial date of coverage.

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

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

1. Is not a Hospital, Extended Care Facility, or Rehabilitation Facility; or
2. Is a unit whose beds are not licensed at a level equal to or more acute than a Skilled Nursing Facility.

Respite Care means Home Health Care services provided temporarily to a Member in order to provide relief to the Member's Immediate Family or other caregiver.

Schedule of Benefits means a summary of the Deductible Amount, Copayment Amount, Coinsurance Amount, Maximum Out-of-Pocket Amount and other limits that apply when you receive Covered Services and supplies.

Self-Injectable Drugs mean Prescription Drugs that are delivered into a muscle or under the skin with a syringe and needle. Although medical supervision or instruction may be needed in the beginning, the patient or caregiver can administer Self-Injectable Drugs safely and effectively.

Serious and Complex Condition means, in the case of an acute Illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or in the case of a chronic Illness or condition, a condition that is life-threatening, degenerative, potentially disabling or congenital; and requires specialized medical care over a prolonged period of time.

Service Area means a geographical area, made up of counties, where we have been authorized by the State of Washington to sell and market our health plans. Those counties are: Adams, Asotin, Benton, Chelan, Clallam, Clark, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Whitman and Yakima. You can receive precise Service Area boundaries from our website or Member Services.

Skilled Nursing Facility (**SNF**) means a Facility (which meets specific regulatory certification requirements) that primarily provides Inpatient skilled nursing care and related services to patients who require medical, nursing or rehabilitative services but does not provide the level of care or treatment available in a Hospital. This is a level of care that requires the daily involvement of skilled nursing or Rehabilitation staff. Examples of Skilled Nursing Facility care include, but not limited to, intravenous injections and physical therapy.

Social Determinants of Health means the circumstances in which people are born, grow up, live, work, and age. This also includes the systems in place to offer health care and services to a community.

Specialist Provider means a Physician or Medical Practitioner who focuses on a specific area of medicine and has additional expertise to help treat specific disorders or illnesses. Specialist Providers may be needed to diagnose, manage or treat certain types of symptoms and conditions related to their specific field of expertise.

Spouse means the person to whom you are lawfully married or state registered domestic partner as required by Washington law.

Stabilize means, with respect to a Member who has not experienced an Emergency Medical Condition, that the Member is no longer experiencing further deterioration as a result of a prior illness or injury and there are no acute changes in physical findings, laboratory results or radiologic results that necessitate acute medical care. Acute medical care does not include Acute Rehabilitation. Stabilize, with respect to a Member who has experienced an Emergency Medical Condition, means to provide medical treatment of the condition as necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer* of the Member to another Facility or discharge of the Member (*See **Ambulance Services Benefits** provision under the **COVERED SERVICES** section).

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

Subscriber means the primary individual who applied for this insurance Contract.

Substance Use Disorder means a substance use condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases.

Surgery means:

1. An invasive diagnostic procedure; or
2. The treatment of a Member's illness or injury by manual or instrumental operations, performed by a Physician while the Member is under general or local anesthesia.

Surgical or Ancillary Services means Surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services.

Surrogacy Arrangement means an understanding in which an individual (the Surrogate) agrees to become pregnant and carry a child (or children) for another person (or persons) who intend to raise the child (or children), whether or not the Surrogate receives payment for acting as a Surrogate.

Surrogate means an individual who, as part of a Surrogacy Arrangement, (a) uses her own egg that is fertilized by a donor or (b) is a gestational carrier who has a fertilized egg placed in her body but the egg is not her own.

Telemedicine means the delivery of health care services through the use of interactive audio and video technology or audio only (**Note**: For audio-only Telemedicine, the Member must have an Established Relationship with the Provider) technology, permitting real-time communication between the patient at the Originating Site and the Provider at the Distant Site, for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include fax, email or text messaging, unless the use of text-like messaging is necessary to ensure effective communication with individuals who have a hearing, speech, or other disability.

Terminal Illness Counseling means counseling of the Immediate Family of a Terminally Ill person for the purpose of teaching the Immediate Family to care for and adjust to the illness and impending death of the Terminally Ill person.

Terminally Ill means a Physician has given a prognosis that a Member has six months or less to live.

Tobacco Use means use of tobacco by individuals who use tobacco on average four or more times per week and within the last six months immediately preceding the date the application for this Contract was completed by the Member, including all tobacco products but excluding religious and ceremonial uses of tobacco.

Transcranial Magnetic Stimulation (**TMS**) means a non-invasive procedure in which a changing magnetic field is used to cause electric current to flow in a small-targeted region of the brain via electromagnetic induction.

Urgent Care means care for a condition that is not an emergency; but is an unforeseen medical illness, injury, or condition that requires immediate care when your Primary Care Provider is unavailable or inaccessible. Your benefits for a no cost preventive care examination may not be used at an Urgent Care Center.

Urgent Care Center means a Facility, not including a Hospital emergency room or a Physician's office, that provides treatment or services that are required:

1. To prevent serious deterioration of a Member's health; and
2. As a result of an unforeseen illness, injury, or the onset of acute or severe symptoms.

Utilization Review means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Areas of review may include ambulatory review, Prior Authorization, second opinion, certification, concurrent review, Care Management, discharge planning, or retrospective review.

Virtual 24/7 Care means a telehealth services benefit through audio/video and audio only technology for virtual Urgent Care and virtual Behavioral Health provided to Members through the Ambetter-designated Telehealth Provider. These services can be accessed through the Ambetter-designated Telehealth Provider's website.

Women's Health Care Services are defined to include, but need not be limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as Medically Necessary, and Medically Necessary follow-up visits for these services. General examinations, well-person preventive visits, and Medically Necessary follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations. Women's Health Care Services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a Women's Health Care Service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and Preventive Care Benefits include, contraceptive services, testing and treatment for sexually transmitted diseases, Pregnancy termination, breast-feeding, Complications of Pregnancy, and screenings for physical, mental, sexual, and reproductive health care needs that arise specifically from sexual assault or Medically Necessary services and prescription medications for treatment of physical, mental sexual, and reproductive health care needs that arise from a sexual assault. "Well-person preventive visits" means the preventive annual visits recommended by the federal health resources and services administration women's preventive services guidelines, with the understanding that those visits must be covered for women, and when medically appropriate, for transgender, nonbinary and intersex individuals.

MEMBER AND DEPENDENT COVERAGE

Member Eligibility

To be eligible for Covered Services, you must be enrolled and covered under the Contract. To be eligible to enroll as a Member you must meet the eligibility criteria listed below or as otherwise required by the Washington Health Benefit Exchange or by the entity through which you enrolled, such as:

1. The primary Member must currently live in the Service Area;
2. Be a Qualified Individual eligible for coverage through the Exchange or through the entity in which you enrolled;
3. Not be eligible for coverage under an employer group health or medical contract; and
4. Not be eligible for Medicare on the date coverage begins.

Member and Dependent Member Effective Date

Eligible persons may apply for coverage by submitting a completed application to the Washington Health Benefit Exchange or to us. Eligible Members and Dependent Members included on the application will not be enrolled or premium will not be accepted until the completed application has been approved.

Your Dependent Members become eligible for coverage under this Contract on:

1. The date you became covered under this Contract; or
2. The date of marriage or date of state registered domestic partnership to add a Spouse; or
3. The date of an eligible newborn’s birth; or
4. The date that an adopted child is placed with the Subscriber for the purposes of adoption or the Subscriber assumes total or partial financial support of the child.

Coverage for a Newborn Child

An Eligible Child born to you or a covered Dependent Member will be covered from the time of birth for up to 21 calendar days after birth even if there are separate Hospital admissions. The newborn child will be covered from the time of birth until the 21st calendar day after birth for Medically Necessary Covered Services. Each type of Covered Service incurred by the newborn child will be subject to the Cost Sharing amount listed in the Schedule of Benefits.

Additional premium payment may be required to continue coverage beyond the 21st calendar day after the date of birth. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to us by the Exchange or by the entity through which you enrolled within the 21 calendar days from birth, an additional premium for coverage of the newborn child will be charged for not less than 21 calendar days after the birth of the child. If notice is not given within the 21 calendar days from birth, we will charge an additional premium from the date of birth. If notice is given by the Exchange or by the entity through which you enrolled within 60 calendar days of the birth of the child, we may not deny coverage of the

child due to failure to notify us of the birth of the child or to pre-enroll the child. Coverage of the child will terminate 21 calendar days after birth, unless we have received notice from either the Exchange or the entity through which you enrolled.

Coverage for an Adopted Child

As used in this provision, “Placement” means the assumption and retention by you or your Spouse for total or partial support of the child in anticipation of the adoption of the child. Placement includes when an Eligible Child is placed in the custody of you or your Spouse pursuant to an interim court order of adoption vesting temporary care of the child in you or your Spouse, regardless of whether a final order granting adoption is ultimately issued.

An Eligible Child legally placed for adoption with you or your Spouse will be covered from the date of Placement until the 31st calendar day after Placement, unless the Placement is disrupted prior to legal adoption and the child is removed from you or your Spouse’s custody.

The child will be covered for loss due to injury and illness, including Medically Necessary care and treatment of conditions existing prior to the date of Placement.

Additional premium payment will be required to continue coverage beyond the 31st calendar day following Placement of the child, and we have received notification from either the Washington Health Benefit Exchange or the entity through which you enrolled. If you enrolled directly with us, please contact Member Services. Notice of the Placement must be given to us within 31 calendar days after the Placement in order to have the coverage continue after the 31 calendar day period and will require payment of the additional premium. The required premium will be calculated from the date of Placement for adoption. Coverage of the child will terminate on the 31st calendar day following Placement, unless we have received both:

1. notification of the addition of the child from either the Washington Health Benefit Exchange or the entity through which you enrolled within 60 calendar days of the birth or Placement and
2. any additional premium required for the addition of the child within 90 calendar days of the date of Placement.

Adding Dependent Members

Dependents should be added or removed through the Washington Health Benefit Exchange or through the entity in which you enrolled. If you enrolled directly with us, please contact Member Services.

Commencement of Benefits for Persons Hospitalized on Effective Date

Members who are admitted to an Inpatient Facility prior to their enrollment under the Contract will receive Covered Services beginning on their Effective Date as set forth above. If a Member is hospitalized in a non-network Facility, we reserve the right to require transfer of the Member to a Network Facility. The Member will be transferred when a Network Provider, in consultation with the Attending Physician, determines that the Member is Medically Stable to do so. If the

Member refuses to transfer to a Network Facility, all further costs incurred during the hospitalization are the responsibility of the Member.

ELIGIBILITY AND ENROLLMENT

For All Members

A Member's eligibility for coverage under this Contract will continue until the earlier of:

1. The date that a Member has failed to pay premiums or contributions in accordance with the terms of this Contract or the date that we have not received timely premium payments in accordance with the terms of this Contract;
2. The date the Member has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact;
3. The date we decline to renew this Contract, as stated in the **Discontinuance** provision;
4. The date of a Member's death;
5. The date of termination that the Exchange provides us upon your request of cancellation to the Exchange, or if you enrolled directly with us, the last calendar day of the month we receive a request from you to terminate this Contract, or any later date stated in your request will be effective the last calendar day of the requested month but no further than 60 calendar days in advance;
6. The Member's coverage is terminated by the Exchange or by the entity through which the Member enrolled; or
7. The primary Member resides outside the Service Area or moves permanently outside the Service Area of this plan.

If you have material modifications (examples include a change in life event (marriage, death) or family status), or questions related to your health insurance coverage, contact the Washington Health Benefit Exchange. If you enrolled directly with us, please contact Member Services.

For Dependent Members

A Dependent Member will continue to be a Member until the end of the premium period in which the Member ceases to be your Dependent Member. For Eligible Children, coverage will terminate the thirty-first of December the year in which the dependent turns 26 years of age. A Member will not cease to be a dependent Eligible Child solely as a result of the 26th birthday if the Eligible Child is and continues to be both:

1. Incapable of self-sustaining employment by reason of developmental or physical disability; and
2. Chiefly dependent on the primary Member for support and maintenance.

Enrollment for such a dependent may be continued for the duration of such incapacity and dependence, provided enrollment does not terminate for any other reason. Proof of incapacity and dependence, such as a statement from the Member's Provider, and proof of financial dependency must be furnished to us upon request, but not more frequently than annually after the two year period following the dependent's attainment of the limiting age. For additional

information on continuing an Eligible Child's coverage beyond their 26th birthday please contact the Exchange or the entity through which you enrolled.

If you have material modifications (examples include a change in life event such as marriage, death or other change in family status) or questions related to your health insurance coverage, please contact the Washington Health Benefit Exchange. If you enrolled directly with us, please contact Member Services.

Open Enrollment

Each year there will be an open enrollment period for coverage. The open enrollment period begins November 1, 2025 and extends through January 15, 2026. If you enroll on or before December 15, 2025 your coverage will be effective on January 1, 2026.

Special Enrollment Periods

A Qualified Individual has 60 calendar days to report a qualifying event to the Exchange or to the entity through which they enrolled and could be granted a 60 calendar day Special Enrollment Period as a result of one of the following events:

1. A Qualified Individual or dependent experiences a loss of Minimum Essential Coverage, non-calendar year group or individual health insurance coverage, pregnancy-related coverage, access to health care services through coverage provided to a pregnant Member's unborn child, or medically needed coverage;
2. A Qualified Individual loses employer sponsored coverage for any reason, including but not limited to death of the employee, termination of employment or reduction in the number of hours of employment, except for misrepresentation of a material fact affecting coverage or for fraud related to the discontinued health coverage;
3. A Qualified Individual experiences the loss of eligibility for Medicaid or a public program providing health benefits;
4. A Qualified Individual gains a dependent or becomes a dependent through marriage, domestic partnership, birth, adoption, foster children, placement for adoption, placement in foster care, or a child support order or other court order;

   In the case of marriage, at least one Spouse must demonstrate having Minimum Essential Coverage as described in 26 CFR 1.5000A-1(b) for one or more calendar days during the 60 calendar days preceding the date of marriage.
5. A Qualified Individual loses coverage as the result of legal separation, dissolution of marriage or termination of a domestic partnership;
6. A Qualified Individual experiences a permanent change in Residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which they were covered does not provide coverage in that person's new Service Area or results in new eligibility for previously unavailable Qualified Health Plans;
7. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the Qualified Individual;

8. Coverage is discontinued in a Qualified Health Plan by the Exchange pursuant to 45 C.F.R. 155.430 and the three month grace period for continuation of coverage has expired;
9. Exhaustion of COBRA coverage due to failure of the employer to remit premium;
10. Loss of COBRA coverage where the Qualified Individual has exceeded the lifetime limit in the plan and no other COBRA coverage is available;
11. A Qualified Individual discontinues coverage under a health plan offered pursuant to the Washington State Health Insurance Coverage Access Act;
12. A Qualified Individual loses coverage as a dependent on a group plan due to age;
13. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month, without requiring an additional special enrollment triggering event;
14. A Qualified Individual loses prior coverage due to errors by the Exchange staff or the U.S. Department of Health and Human Services (HHS);
15. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
16. A Member demonstrates to the Exchange that the Qualified Health Plan in which the Member is enrolled violated a material provision of its Contract in relation to the Member's decision to purchase the Qualified Health Plan based on plan benefits, Service Area or premium;
17. An individual is determined newly eligible or newly ineligible for Advance Premium Tax Credit or has a change in eligibility for Cost Sharing Reductions, or the individual's dependent becomes newly eligible;
18. The individual or their dependent who is currently enrolled in employer sponsored coverage is determined to be newly eligible for Advance Premium Tax Credits;
19. A Qualified Individual or dependent is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
20. A Qualified Individual or dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 calendar days after the qualifying event; or
21. At the option of the Exchange, a Qualified Individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a Qualified Health Plan through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence.

If the Member eligible for the special enrollment period had prior coverage, they will be offered the benefit packages available to individuals who enrolled during the open enrollment period

within the same metal tier or level at which the Member had previously. Any difference in benefits or Cost Sharing requirements for different individuals constitutes a different benefit package. An eligible Member will not be required to pay more for coverage than a similarly situated individual who enrolls during open enrollment. A Member who was enrolled in a catastrophic plan as defined in RCW 48.43.005(8) may be limited to the plans available during open enrollment at either the bronze or silver level. A Member whose eligibility is based on their status as a dependent may be limited to the same metal tier for the plan on which the primary Subscriber is enrolled. The Exchange may require reasonable proof or documentation that an individual seeking special enrollment has experienced a qualifying event.

This section should not be interpreted to limit the Exchange's rights to automatically enroll Qualified Individuals based on good cause or exceptional circumstances as defined by the Exchange or as required by the U.S. Department of Health and Human Services.

Qualified Individuals who enroll and pay their first month’s premium between the first and the last calendar day of the month will have a coverage Effective Date of the first calendar day of the following month. In the case of birth, adoption, foster care, placement for adoption or placement for foster care, the coverage is effective on the date of birth, adoption, foster care, placement for adoption or placement for foster care, but advance payments of the premium tax credit and Cost Sharing Reductions, if applicable, are not effective until the first calendar day of the following month, unless the birth, adoption, foster care, placement for adoption or placement for foster care occurs on the first calendar day of the month. In the case of marriage or the beginning of a domestic partnership, or in the case where the Qualified Individual experiences a loss of Minimum Essential Coverage, the Effective Date is the first calendar day of the following month.

American Indians/Alaskan Natives eligible for services through an Indian health care Provider may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month. Please contact the Exchange for more information.

Prior Coverage

If a Member is confined as an Inpatient in a Hospital on the Effective Date of this Contract, and prior coverage is terminating immediately before the Effective Date of this Contract then services and benefits will not be covered under this Contract for that Member until the Member is discharged from the Hospital or benefits under the prior coverage are exhausted, whichever is earlier.

If there is no prior coverage or no continuation of Inpatient services after the Effective Date, your coverage will apply for Covered Services related to the Inpatient services after your Effective Date. Your coverage requires you to notify us within two calendar days of your Effective Date so we can review and Authorize Medically Necessary services. If services are at a non-contracted Hospital, Claims will be paid at the Allowed Amount and you may be billed for any balance of costs above the Allowed Amount.

PREMIUMS

Premium Payment

Each monthly premium is to be paid to Ambetter from Coordinated Care before the first calendar day of the month for coverage to ensure there is no disruption of services. Full premium payments that are received during the grace period described below will be processed and your eligibility for coverage will be updated within two business days after receipt. Ambetter reserves the right to apply any rewards that may be converted to monetary value earned through My Health Pays or any similar program to any unpaid premium or related amounts you may owe.

Grace Period

When a Member is receiving a premium subsidy:

If full premium is not paid by the due date, then a grace period of three consecutive months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period.

We will continue to pay all appropriate Claims for Covered Services rendered to the Member during the first month of the grace period. In the second and third month of the grace period, the Member's coverage is suspended and we will pend the processing of Claims for Covered Services, including Pharmacy transactions, rendered to the Member.

If full payment of premium is received after the grace period is initiated, any pended Claims will be processed within 30 calendar days after receipt of payment. If full payment of premium is not received within the grace period, coverage will be terminated as of the last calendar day of the first month during the grace period and any Claims for services after the term date will be denied.

We will notify the Exchange of the non-payment of premiums, and notify the Member, as well as Providers of the possibility of denied Claims when the Member is in the second and third month of the grace period. We will continue to collect Advance Premium Tax Credits on behalf of the Member from the Department of the Treasury, and will return the Advance Premium Tax Credits on behalf of the Member for the second and third month of the grace period if the Member exhausts their grace period as described above.

When a Member is not receiving a premium subsidy:

If full premium is not paid by the due date, then a grace period of one month from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. The Member's coverage is suspended and we will pend the processing of Claims for Covered Services, including Pharmacy transactions, rendered to the Member.

If full payment of premium is received after the grace period is initiated, any pended Claims will be processed within 30 calendar days after receipt of payment. If full payment of premium is not received within the grace period, coverage will be terminated as of the last calendar day of the month prior to the grace period and any Claims for services after the term date will be denied.

We will notify the Exchange, as necessary, of the non-payment of premiums, the Member, as well as Providers of the possibility of denied Claims when the Member is in the grace period.

Third-Party Payment of Premiums or Cost Sharing

We require each Contract holder to pay their premiums and this is communicated on your monthly billing statements. Our payment policies were developed based on guidance from the Centers for Medicare and Medicaid Services (CMS) recommendations against accepting third-party premiums. Consistent with CMS guidance, the following are the ONLY acceptable third parties who may pay premiums on your behalf:

1. Ryan White HIV/AIDS program under title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations or urban Indian organizations;
3. State and federal government programs;
4. Certain tax-exempt organizations;
5. Family members;
6. An employer for an employee under an Individual Coverage Health Reimbursement Account (ICHRA) or Qualified Small Employer Health Reimbursement Account (QSEHRA) plan;
7. Private, not-for-profit foundations which have no incentive for financial gain, no financial relationship, or affiliation with Providers of Covered Services and supplies on behalf of Members, where eligibility is determined based on defined criteria without regard to health status and where payments are made in advance for a coverage period from the Effective Date of eligibility through the remainder of the calendar year; or
8. Approved premium sponsorship programs.

Upon discovery that premiums were paid by a person or entity other than those listed above, we may reject the payment and inform the Member that the payment was not accepted and that the premium charges remain due.

Misstatement of Age

If a Member's age has been misstated, the Member’s premium may be adjusted to what it should have been based on the Member’s actual age.

Change of Residence

If you change your Residence, you must notify the Exchange or the entity through which you enrolled of your new Residence within 60 calendar days of the change. As a result, your premium may change and you may be eligible for a Special Enrollment Period. See the **Special Enrollment Periods** provision in the **ELIGIBILITY AND ENROLLMENT** section for more information.

Right to Change Premium

We have the right to change premiums after filing and receiving approval by the state of Washington. We will change the rate table used for this Contract form annually. Each premium will be based on the rate table in effect on that premium's due date. Factors used in determining your premium rates may include: geographic area, family size, age, tenure discounts and wellness activities. Additionally, the premium may be changed more frequently to reflect changes to: family composition, the health benefit plan requested by you, or government requirements affecting the health benefit plan.

If we change your premium, we will provide 30 calendar day notice delivered to you at your last address as shown in our records. We will make no change in your premium solely because of Claims made under this Contract or a change in a Member's health. While this Contract is in force, we will not restrict coverage already in force.

COST SHARING FEATURES

Cost Sharing Features

We will pay benefits for Covered Services as described in the Schedule of Benefits and the **COVERED SERVICES** section of this Contract. All benefits we pay will be subject to all conditions, limitations, and Cost Sharing features of this Contract. Cost Sharing means that you participate or share in the cost of your health care services by paying Deductible Amounts, Copayments and Coinsurance for some Covered Services. For example, you may need to pay a Deductible, Copayment or Coinsurance Amount when you visit your Physician or are admitted into the Hospital. The Copayment or Coinsurance required for each type of service as well as your Deductible is listed in your Schedule of Benefits.

When you, or a covered dependent, receive health care services from a Provider, there may be multiple Claims for that episode of care. An episode of care means the services provided by a health care Facility or Provider to treat a condition or an illness. Each Claim that we receive for services covered under this Contract are adjudicated or processed as we receive them. Coverage is only provided for Eligible Expenses. Each Claim received will be processed separately according to the Cost Share as outlined in the Contract and in your Schedule of Benefits.

Deductible

Some Covered Services are subject to an annual Deductible. The Deductible means the amount of Covered Services, including Prescription Drugs, that must be paid by the Member(s) before any benefits are payable.

There is an individual annual Deductible for each Member and a maximum annual Deductible for family coverage. The family Deductible Amount is two times the individual Deductible Amount. For family coverage, the family Deductible can be met with the combination of any one or more covered Members' Eligible Expenses. Coinsurance Amounts and Copayment Amounts for services not subject to the Deductible do not apply toward the Deductible Amount but do apply toward the Maximum Out-of-Pocket Amount. Copayment Amounts and Coinsurance Amounts for services subject to the Deductible apply toward the Deductible Amount and the Maximum Out-of-Pocket Amount. Please see your Schedule of Benefits or call Member Services for additional information.

For family coverage, all Members contribute to their individual Deductible Amount. The individual Deductible Amount applies to the family Deductible Amount. However, if a single individual meets their Deductible Amount, they will no longer be required to contribute to the family Deductible Amount. It will be the remaining family members that will continue to contribute to their individual Deductible Amount which will continue to apply to the family Deductible Amount until met.

Copayments

A Copayment is a fixed dollar amount typically due (and payable to the Provider or Facility) at the time of service. Members may be required to pay Copayments to a Provider each time services are performed that require a Copayment. Copayments, as shown in your Schedule of

Benefits, are due at the time of service. Payment of a Copayment does not exclude the possibility of a Provider billing you for any services not covered by your benefits.

Coinsurance Percentage

A Coinsurance Amount is your share of the cost of a service. Members may be required to pay a Coinsurance Amount in addition to any applicable Deductible Amount(s) due for a Covered Service or supply.

Maximum Out-of-Pocket

You must pay any applicable Deductible Amounts, Copayment Amounts or Coinsurance Amounts required until you reach the Maximum Out-of-Pocket Amount shown in your Schedule of Benefits. After the Maximum Out-of-Pocket Amount is met for an individual, we will pay 100 percent of the cost for Covered Services. The family Maximum Out-of-Pocket Amount is two times the individual Maximum Out-of-Pocket Amount. For the family Maximum Out-of-Pocket Amount, the family Maximum Out-of-Pocket Amount can be met with the combination of any one or more Members' Eligible Expenses.

For family coverage, all Members contribute to their individual Maximum Out-of-Pocket Amount. The individual Maximum Out-of-Pocket Amount applies to the family Maximum Out-of-Pocket Amount. However, if a single individual meets their Maximum Out-of-Pocket Amount, they will no longer be required to contribute to the family Maximum Out-of-Pocket Amount. It will be the remaining family members that will continue to contribute to their individual Maximum Out-of-Pocket Amount which will continue to apply to the family Maximum Out-of-Pocket Amount until met.

When the annual Maximum Out-of-Pocket Amount has been met, additional Covered Services will be provided or payable at 100 percent of the Allowed Amount.

The amount provided or payable will be subject to:

1. Any specific benefit limits stated in the Contract;
2. A determination of Eligible Expenses; and
3. Any reduction for expenses incurred at a Non-Network Provider.

The applicable Deductible Amount(s), Copayment Amounts and Coinsurance Amounts are shown in your Schedule of Benefits.

Non-Network Liability and Balance Billing

If you receive services from a Non-Network Provider, you may have to pay more for services you receive. Non-Network Providers may be permitted to bill you for the difference between what we agreed to pay and the full Billed Amount for a service. This is known as Balance Billing. This amount is likely more than Network costs for the same service and might not count toward your annual Maximum Out-of-Pocket Amount limit. However, you are not responsible for Balance Billing when Balance Billing Protections apply to Covered Services.

ACCESS TO CARE

Primary Care Provider

To obtain Covered Services, we require you to designate a Primary Care Provider (PCP) for each Member. You may select any PCP who is accepting new patients. If you do not select a PCP for each Member, one will be assigned. You may get a list of PCPs within our Network, CCCWA Exchange, at our website or by contacting Member Services. Members may choose to have any Physician or Medical Practitioner listed under "**Women's Health Care Direct Access Providers**" in this section as their PCP.

Your PCP is responsible for coordinating all Covered Services with other Network Providers. The requirements for Prior Authorization are contained in this Contract. Services may not be covered if the Prior Authorization requirements are not met. Please refer to the PRIOR AUTHORIZATION section of this Contract and your Schedule of Benefits for additional information.

Members do not need a referral from their PCP for mental or Behavioral Health services or for obstetrical or gynecological treatment and may seek care directly from a Provider as described in the "**Women's Health Care Direct Access Providers**" provision in this section.

You may change your PCP at any time by submitting a written request, online at our website, or by contacting our office at the number shown on your Member identification card. We can make your choice of PCP effective on the next business day, if the selected Physician caseload permits. The change will be effective no later than the beginning of the month following your change request.

We will notify you if your PCP leaves our Network. You will be provided access to the Provider for at least 60 calendar days from that notice. During those 60 calendar days, we will offer you a selection of new PCPs from which to choose.

Contacting Your Primary Care Provider

To make an appointment with your PCP, call his/her office during business hours and set up a date and time. If you need help, call Member Services and we will help you make the appointment.

If you need to cancel or change your appointment, call 24 hours in advance. At every appointment, make sure you bring your Member identification card and a photo identification.

Should you need care outside of your PCP's office hours, you should call your PCP's office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your PCP during normal office hours, call our 24/7 nurse advice line at 1-877-687-1197 (TTY: 711). A licensed nurse is always available and ready to answer your health questions. If you are experiencing an Emergency Medical Condition, call 911 or go to the nearest emergency room. For a Behavioral Health crisis, call or text 988.

Network Availability

The Network is subject to change. The most current Network may be found online at our website or by contacting us at the number shown on your Member identification card. A Network may not be available in all areas. If you move to an area where we are not offering access to a Network, please contact the Washington Health Benefit Exchange or the entity through which you enrolled prior to moving, but no more than 60 calendar days from the date of the event. You may have the opportunity to disenroll from coverage under this Contract and enroll in a different health plan with a Network in that area. **Note:** Services received from Non-Network Providers are generally not Covered Services under this Contract, except when Balance Billing Protections apply to a Covered Service provided by a Non-Network Provider. If you receive Covered Services from Non-Network Providers that are not subject to Balance Billing Protections, benefits will be calculated in accordance with the terms of this Contract for Non-Network Providers.

Specialist Providers

Unless otherwise indicated in this Contract, Prior Authorization may be required for services received from a Specialist Provider. Prior Authorization is not required for an initial evaluation and management visit and up to six consecutive treatment visits with a contracted Provider in a new episode of care of chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, or speech and hearing therapies that meet the standards of medical necessity. If you have a chronic medical condition, you may request a standing Authorization for specialist services. Some Specialist Providers may act as a PCP for Members with a severe chronic medical condition. This is permitted if the Specialist Provider provides all basic health care services and they are contracted with us as a PCP. Contact Member Services to find out which Providers serve in both roles.

Second Opinions

If requested, you may access a second opinion consultation regarding a medical diagnosis or treatment plan from a Network Provider. You may select a Network Provider listed in the Provider Directory. If you choose a Network Provider, you will be responsible for the applicable Cost Share amount for the consultation. Any laboratory, diagnostic tests and/or therapeutic services are subject to additional Cost Share.

If a second medical opinion is obtained by a Non-Network Provider, Prior Authorization must be obtained before services are considered a Covered Service. If Prior Authorization is not obtained for a second medical opinion from a Non-Network Provider, you will be responsible for the related expenses and you may be Balance Billed for services received.

Emergency and Urgent Care

Emergency Care

Emergency Services do not need Prior Authorization. Emergency care is available at Network Hospitals and Facilities. If you cannot get to a Network Facility, you may obtain Emergency Services from the nearest Hospital regardless of if they are a Network Provider (see the

Hospital Based Providers provision below). Members or persons assuming responsibility for a Member must notify us the next business day following admission to a non-network Facility, or as soon thereafter as medically possible. If a Member is admitted to a Network Hospital or an Inpatient Behavioral Health Facility directly from the emergency room, the Facility is responsible for notifying us of the admission by the next business day following admission. The emergency Cost Share is waived. However, coverage will be subject to any Inpatient Cost Sharing.

The Hospital or Behavioral Health Emergency Services Provider must notify us within 48 hours of stabilization or by the end of the business day following the day of stabilization, whichever is later.

Urgent Care

In the Service Area, Urgent Care is covered at Network Hospitals and Urgent Care Centers, or Network Providers' offices. Your Preventive Care Benefits may not be used at an Urgent Care Center.

Outside our Service Area, if Authorized, Urgent Care is covered at any medical Facility. Members are responsible for Cost Share amounts and may be responsible for amounts above the Eligible Expense.

Non-Network Providers at Hospitals or Ambulatory Surgical Facilities

A Non-Network Provider cannot Balance Bill you for services provided at a Network Hospital, or for Surgical or Ancillary Services provided at a Network Ambulatory Surgical Center. If you are treated by a Non-Network Provider at a Network Hospital or Ambulatory Surgical Center, your Cost Sharing responsibility for the non-network services will be no greater than if the Provider had been in our Network.

Transfer to Network Facility

If a Member is hospitalized in a non-network Facility, we reserve the right to require transfer of the Member to a Network Facility. The Member will be transferred when a Network Provider, in consultation with the Attending Physician, determines that the Member is Medically Stable for transfer. If the Member refuses to transfer to a Network Facility, all further costs incurred during the hospitalization are the responsibility of the Member.

Women's Health Care Direct Access Providers

Members may see a Network Provider, general and family practitioner, physician assistant, gynecologist, certified nurse midwife, licensed midwife, doctor of osteopathy, pediatrician, obstetrician or advanced registered nurse practitioner who is contracted by us to provide Women's Health Care Services directly, without a referral, for Medically Necessary maternity care, covered reproductive health services, preventive care (well care) and general examinations, gynecological care and follow-up visits for the above services. Women's Health Care Services are covered as if the Member's Primary Care Provider had been consulted, subject to any applicable Cost Sharing, as set forth in your Schedule of Benefits.

Telemedicine and Virtual 24/7 Care

You may receive services from your Provider from your home or other location away from your Provider's office. Telemedicine covers Covered Services received using audio and video technology. In addition to services by your Provider, Virtual 24/7 Care is available by telephone or audio and video technology that you can access nationwide.

Service Area

Ambetter from Coordinated Care operates in a limited Service Area. Most Providers in Ambetter from Coordinated Care's Provider Network in Washington (CCCWA Exchange) are located in the Service Area, however some may be in the Network and located in the adjacent county or state. These Providers are shown on the "Find a Doctor" tool at AmbetterHealth.com/en/WA.

If you move from one county to another within the Service Area your premium may change. Please refer to the **PREMIUM** section of this Contract for more information. If you move from a county in the Service Area to a county not in the Service Area, you will no longer be eligible for coverage under this Contract and may be eligible for enrollment into another Qualified Health Plan during a Special Enrollment Period.

Providers Outside of Washington

Emergency Services

When you receive Emergency Services and supplies outside of Washington State, but within the United States of America, Covered Services and supplies for Emergency Medical Conditions can be furnished by any Emergency Services Provider that meets the following requirements:

1. State-licensed or state-certified;
2. Performing services within the scope of their license or certification.

Emergency Services for those out-of-state Facilities will be subject to the No Surprises Act's protection against Balance Billing. If, by chance, you get Emergency Services from a Provider that has a contract with Ambetter outside of Washington State, your Out-of-Pocket Expenses may be reduced. This is because those Providers have agreed to accept our Allowed Amount for Covered Services as payment in full. When you receive covered emergency care from one of these contracted Providers, you are responsible only for any Cost Sharing (Deductible Amount, Copayment Amount or Coinsurance Amount) required by this plan.

Non-Emergency Services

If you are traveling outside of Washington, you may be able to access Providers in another state if there is an Ambetter plan located in that state. You can locate Network Providers outside of Washington by searching the relevant state in our Provider directory at guide.ambetterhealth.com. Not all states have Ambetter plans. If you receive care from an Ambetter Provider outside of the Service Area, you may be required to receive a Prior

Authorization for non-emergency services. Contact Member Services at the phone number on your Member identification card for further information.

Continuity of Care

Under the federal No Surprises Act, if a Member is a Continuing Care Patient with respect to a Network Provider and the contractual relationship with the Provider is terminated, such that the Provider is no longer in the Network; or benefits are terminated because of a change in the terms of the participation of the Provider, as it pertains to the services the Member is receiving as a Continuing Care Patient, then we will:

1. Notify the Member on a timely basis of the termination and their right to elect continued transitional care from the Provider;
2. Provide the Member individual with an opportunity to notify us of the Member's need for transitional care; and
3. Permit the Member to elect to continue to have their benefits for the course of treatment relating to their status as a Continuing Care Patient during the period beginning on the date on which the notice described in 1. is provided and ending on the earlier of:
    a. 90 calendar days after the notice described in 1. is provided; or
    b. The date on which such Member is no longer a Continuing Care Patient with respect to the Provider.

Hospital Based Providers

You may not be Balanced Billed for Covered Services that are subject to Balance Billing Protections as described in the **DEFINITIONS** section of this Contract. When receiving care at a Network Hospital, it is possible that some Hospital Based Providers may not be Network Providers. If there is Notice and Consent to waive Balance Billing Protections, you may be responsible for payment of all or part of the Balance Bill. Any amount you are obligated to pay to the Non-Network Provider in excess of the Eligible Expense will not apply to your Deductible Amount or Maximum Out-of-Pocket Amount.

COVERED SERVICES

You are covered for the Medically Necessary Covered Services and supplies provided by Network Providers as described in this Contract and the Schedule of Benefits. Covered Services must be Medically Necessary and not Experimental or Investigational, except as otherwise described in this Contract. You will be required to pay any applicable Copayment, Coinsurance and Deductible Amounts. Copayment Amounts must be paid to your Network Provider at the time you receive services.

Essential health benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Use Disorder services, including Behavioral Health treatment; Prescription Drugs; Rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (services covered for a Member until the end of the month they reach the age of 19), including vision care. Essential health benefits provided within this Contract are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum.

Some services and supplies require Prior Authorization in order to be Covered Services. Please refer to the **PRIOR AUTHORIZATION** section in this Contract or contact Member Services for questions regarding Prior Authorization.

All Covered Services and supplies are subject to the conditions, terms, provisions, limitations and exclusions described in this Contract and your Schedule of Benefits. Benefit limitations may also apply to some Covered Services that fall under more than one Covered Service category. Please review all limits carefully. Ambetter from Coordinated Care will not pay benefits for any of the services, treatments, items or supplies that exceed benefit limits.

Acquired Brain Injury Services

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition if such services are necessary as a result of and related to an Acquired Brain Injury and include:

1. Cognitive Rehabilitation Therapy
2. Cognitive communication therapy
3. Neurocognitive therapy and Rehabilitation
4. Neurobehavioral, neurophysiological and psychophysiological testing and treatment
5. Neurofeedback therapy
6. Remediation required for and related to treatment of an Acquired Brain Injury
7. Post-acute transition services and community reintegration services, including outpatient day treatment services.

Treatment for an Acquired Brain Injury may be provided at a Hospital, an acute or post-acute Rehabilitation Hospital, a Skilled Nursing Facility or an approved Facility where Covered Services are provided. Treatment goals for services may include the maintenance of,

functioning or the prevention or slowing of further deterioration. Custodial Care and long-term nursing care are not Covered Services under this Contract.

To ensure that appropriate post-acute care treatment is provided, this Contract includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

1. Has incurred an Acquired Brain Injury;
2. Has been unresponsive to treatment;
3. Is medically stable; and
4. To ensure that appropriate post-acute care treatment is provided, this plan includes coverage for expenses related to periodic reevaluation of the care of an individual covered with the expectation that with the provision of these services and support, the person can return to a community-based setting, rather than reside in a Facility setting.

Acupuncture

Covered Services and supplies for acupuncture treatment are provided on an outpatient basis only when rendered by Network Providers. See your Schedule of Benefits for benefit levels.

Alternative Care – Home Health Care or Hospice

We cover alternative care as an alternative to hospitalization. Coverage shall be offered to Members who may be at home and would otherwise require hospitalization or institutional expenses. Coverage will include substitution of Home Health Care, provided in lieu of hospitalization or other institutional care, furnished by a Network Home Health provider, Hospice and Home Health Care Agencies. Substitution of less expensive or less intensive services shall be made only with the consent of the Member and upon the recommendation of the Member's Attending Physician or licensed Medical Practitioner that such services will adequately meet the Member's needs.

Home Health Care and Hospice care coverage offered shall conform to the following standards, limitations, and restrictions:

1. Such expenses will include coverage for Durable Medical Equipment which permits the Member to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, Home Health, Hospice and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.
2. Coverage will be limited to the maximum benefits which would be payable for Hospital or other institutional expenses under the Contract and will include all Cost Sharing payable by the Member under the Hospital or other institutional expense coverage of the Contract.
3. The coverage will require that Home Health Agencies and similar alternative care Providers have written treatment plans approved by the Member's Attending Physician or other licensed Medical Practitioner.

Ambulance Service Benefits

Air Ambulance Service Benefits

Covered Services will include ambulance services for transportation by fixed wing and rotary wing air ambulance from home, scene of accident or Emergency Medical Condition, subject to other coverage limitations discussed below:

1. In cases where the Member is experiencing an Emergency Medical Condition to the nearest Hospital that can provide services appropriate to treat the Member's Emergency Medical Condition;
2. To the nearest neonatal special care unit for newborn infants for treatment of illnesses, injuries, congenital birth defects or complications of premature birth that require that level of care;
3. Transportation between Hospitals or between a Hospital and a more appropriate level of care, when Authorized by us;
4. When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse; or
5. When a Member is required by us to move from a Non-Network Provider to a Network Provider.

Non-emergency air ambulance services require Prior Authorization. Prior Authorization is not required for air ambulance services when the Member is experiencing an Emergency Medical Condition. **Note:** You should not be Balance Billed for covered air ambulance services.

Limitations: Benefits for air ambulance services are limited to:

1. Services requested by police or medical authorities at the site of an emergency.
2. Those situations in which the Member is in a location that cannot be reached by ground ambulance.

Exclusions:

No benefits will be paid for:

1. Air ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-emergency air ambulance services, unless Prior Authorization is obtained.
3. Air ambulance services:
    a. Outside of the 50 United States and the District of Columbia;
    b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
    c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.
4. Air ambulance services provided for a Member's comfort or convenience.
5. Non-emergency air transportation (for example, commercial flights).

Ground Ambulance Service Benefits

Covered Services will include ambulance services for ground transportation from home, scene of accident or Emergency Medical Condition, subject to other coverage limitations discussed below:

1. In cases where the Member is experiencing an Emergency Medical Condition, to the nearest Hospital or Behavioral Health Emergency Services Provider that can provide services appropriate to treat the Member's Emergency Medical Condition.
2. To the nearest neonatal special care unit for newborn infants for treatment of illnesses, injuries, congenital birth defects, or complications of premature birth that require that level of care.
3. Transportation between Hospitals or Behavioral Health Emergency Services Providers or between a Hospital or Behavioral Health Emergency Services Provider and a more appropriate level of care, when Authorized by us.
4. When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse.
5. When a Member is required by us to move from a Non-Network Provider to a Network Provider.

Non-emergency ground ambulance services require Prior Authorization. Prior Authorization is not required for ground ambulance services when the Member is experiencing an Emergency Medical Condition. **Note:** You should not be Balance Billed for covered ground ambulance services.

Exclusions:

No benefits will be paid for:

1. Expenses incurred for ground ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-emergency ground ambulance services, unless Prior Authorization is obtained.
3. Ground ambulance services provided for a Member's comfort or convenience.
4. Non-emergency ground transportation (for example, transport van, taxi, ride sharing).

Water Ambulance Service Benefits

Covered Services will include ambulance services for water transportation from home, scene of accident or Emergency Medical Condition, subject to other coverage limitations discussed below:

1. In cases where the Member is experiencing an Emergency Medical Condition, to the nearest Hospital that can provide Emergency Services appropriate to treat the Member's Emergency Medical Condition.
2. To the nearest neonatal special care unit for newborn infants for treatment of illnesses, injuries, congenital birth defects, or complications of premature birth that require that level of care.

3. Transportation between Hospitals or between a Hospital and a more appropriate level of care, when Authorized by us.
4. When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse.
5. When a Member is required by us to move from a Non-Network Provider to a Network Provider.

Prior Authorization is not required for emergency water ambulance transportation. **Note:** Non-emergency water ambulance transportation requires Prior Authorization. Unless otherwise required by federal or Washington law, if you receive services from a non-network ambulance provider, you may be Balanced Billed.

Benefits for water ambulance services are limited to services requested by police or medical authorities at the site of the emergency.

Exclusions:

No benefits will be paid for:

1. Expenses incurred for water ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-emergency water ambulance services, unless Prior Authorization is obtained.
3. Water ambulance services provided for a Member's comfort or convenience.
4. Non-emergency water transportation (for example, ferry, water taxi).

Ambulatory Patient Services

Covered Service and supply expenses for ambulatory patient services will include Medically Necessary services delivered in settings other than a Hospital or Rehabilitation or Extended Care Facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury. Such services include Network:

1. Hospice and Home Health Care, including skilled nursing care as an alternative to hospitalization;
2. Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;
3. Urgent Care Center visits, including Provider services, Facility costs and supplies;
4. Ambulatory Surgery Center (see below provision);
5. Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures;
6. Oral Surgery related to trauma and injury, including services or appliances necessary for or resulting from medical treatment if the service is either emergency in nature or requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease; and
7. Physician contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.

Ambulatory Surgical Center

Outpatient Services and supplies provided at a Network Ambulatory Surgery Center including:

1. Anesthesiology;
2. Surgical Services;
3. Laboratory Services;
4. Recovery Care;
5. Patient Care Services;
6. Surgical supplies; and
7. Facility costs (including services of staff Providers billed by the Hospital).

Autism Spectrum Disorder Benefits

Coverage is provided for Autism Spectrum Disorders when prescribed by a Physician or Behavioral Health Practitioner and includes the following:

1. Evaluation and assessment services;
2. Applied Behavior Analysis therapy;
3. Behavior training and behavior management;
4. Habilitation Services;
5. Rehabilitation Services;
6. Psychiatric care such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor or clinical social worker; and
7. Medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

No limitation exists within the benefits for Applied Behavior Analysis services. These services are subject to Prior Authorization to determine Medical Necessity. If multiple services are provided on the same day by different Providers, a separate Deductible, Copayment and/or Coinsurance will apply to each provider.

Care Management Programs

We understand special health needs and are prepared to help you manage any that you may have. Our Care Management services can help with complex medical or Behavioral Health needs. If you qualify for Care Management, we will partner you with a care manager. Care managers are specially trained to help you:

1. Better understand and manage your health conditions
2. Coordinate services
3. Locate community resources

Your care manager will work with you and your doctor to help you get the care you need. If you have a severe medical condition, your care manager will work with you, your Primary Care Provider (PCP) and other providers to develop a care plan that meets your needs and your caregiver's needs.

If you think you could benefit from our Care Management program, please call Member Services.

Chiropractic Care

Covered Services and supplies include Medically Necessary Chiropractic Care to treat or diagnose neuromusculoskeletal disorders on an outpatient basis only when rendered by Network Providers. See your Schedule of Benefits for benefit levels or additional limits. Covered Service and supply expenses are subject to all other terms and conditions of the Contract, including Deductible Amount, Copayment Amount and Coinsurance Amount provisions.

Clinical Trials

"Clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, funded or approved by:

1. One of the National Institutes of Health (NIH);
2. An NIH cooperative group or center which is a formal Network of Facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;
3. The federal Departments of Veterans Affairs or Defense;
4. A review board of an institution in this state with a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH; or
5. A qualified research entity that meets the criteria for NIH Center Support Grant eligibility.

We will cover Medically Necessary routine costs for Members who participate in a clinical trial if:

1. The clinical trial is undertaken for the purpose of prevention, early detection or treatment of cancer or other life-threatening illnesses or condition for which no standard or more effective standard treatment exists;
2. The clinical trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology;
3. The clinical trial is being provided in Washington State as part of a scientific study of a new therapy or intervention that is being conducted at an institution in Washington and is for the treatment, palliation or prevention of cancer or disease in humans with: specific goals; a rationale and back ground for the study; criteria for patient selection; specific direction for administering the therapy or intervention and for monitoring

patients; a definition of quantitative measures for determining treatment response; methods for documenting and treating adverse reactions; and a reasonable expectation that the treatment will be at least as effective as standard cancer treatment or other life threatening illness treatment; and

4. The personnel providing the clinical trial or conducting the study (a) are providing the clinical trial or conducting the study within their scope of practice, experience and training and are capable of providing the clinical trial because of their experience, training and volume of patients treated to maintain their expertise; (b) agree to accept reimbursement as payment in full from us and that is not more than the level of reimbursement applicable to other similar services provided by the Network Providers within our Network; and (c) agree to provide written notification to us when a patient enters or leaves a clinical trial.

Medication prescribed as part of a clinical trial which is not the subject of the trial, will be covered as other Prescription Drugs under the Contract. Participation in clinical trials is subject to Prior Authorization requirements as outlined in this Contract.

Covered Services and supplies for clinical trials will not include:

1. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
2. Items and services provided solely to satisfy data collection and analysis needs;
3. Items and services that are not used in the direct clinical management of the Member; or
4. The Investigational item, device, or service itself.

"**Life threatening condition**" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"**Routine costs**" means items and services delivered to the Member that are consistent with and typically covered by the Contract for a Member who is not enrolled in a clinical trial. The Member will be responsible for any Cost Sharing amounts related to the use of Network services.

Colorectal Cancer Screening

Covered Services and supplies include colorectal screenings for determining the presence of precancerous or cancerous conditions and other health problems. Screenings options include simple at-home testing kits, which are appropriate in the right clinical setting, as well as a colonoscopy examining the entire colon. Both options are available through Network Providers for adults over 45 or adults under 45 when at high risk for colorectal cancer and in accordance with the recommendations established by the United States Preventive Services task force. Whether something is preventive is determined by us when reviewing the type of health care service information and diagnosis codes submitted by the Provider on the Claim form.

There are several types of colonoscopies performed for different reasons:

1. Preventive Colon Cancer Colonoscopy – a colonoscopy is considered a type of colorectal screening and covered in accordance with the USPSTF recommendations,

when there are no signs or symptoms of illness (such as bleeding, change in bowel habits or pain) or if you have not been previously diagnosed with cancerous colon polyp(s). This is considered a preventive screening and is covered at no charge. Please refer to the **Preventive Care Benefits** provision for more information about preventive services.

Note: If your Provider performs a polyp biopsy during a recommended preventive colonoscopy, the Provider should bill the biopsy and related labs as preventive, and no Member Cost Sharing will apply.

2. Diagnostic – colonoscopies for those who previously had a cancerous polyp or other prior conditions in the bowel are not considered preventive screening colonoscopies. When you have symptoms a colonoscopy is considered diagnostic in nature and your plan's Cost Sharing will apply.

Craniomandibular Joint (CMJ) and Temporomandibular Joint (TMJ) Dysfunction Conditions

Covered Services and supplies include Medically Necessary services, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint. Prior Authorization may be required prior to receiving services or supplies. See your Schedule of Benefits for benefit levels or additional limits.

Diabetes Coverage

Benefits are provided for Medically Necessary Covered Services and supplies used in the treatment of persons with gestational, type I or type II diabetes.

Covered Services and supplies include, but are not limited to:

1. Insulin,
2. Syringes,
3. Injection aids,
4. Blood glucose monitors,
5. Test strips for blood glucose monitors,
6. Visual reading and urine test strips,
7. Insulin pumps and accessories to the pumps,
8. Insulin infusion devices,
9. Prescriptive oral agents for controlling blood sugar levels,
10. Foot care appliances for prevention of complications associated with diabetes,
11. Glucagon emergency kits, and
12. Educational health and nutritional counseling for self-management training and education, eye examinations, prescription medications and retinopathy examination screenings, as Medically Necessary.

Prior Authorization may be required prior to receiving some services and supplies.

Insulin: The total amount you will be required to pay for a covered insulin drug will not exceed any state and/or federal mandated limits. Any Cost Share amount you pay will be applied to the Deductible Amount.

Dialysis Services

Medically Necessary acute and chronic dialysis services are Covered Services. Coverage for End Stage Renal Disease patients for whom Medicare is Primary, benefits will be payable subject to the **COORDINATION OF BENEFITS** section of this Contract. There are two types of treatment, provided you meet all the criteria. You may receive hemodialysis in a Network dialysis Facility or peritoneal dialysis in your home from a Network Provider.

Covered Service and supply expenses include:

1. Services provided in an outpatient dialysis Facility or when services are provided in the home;
2. Processing and administration of blood or blood components;
3. Dialysis services provided in a Hospital;
4. Dialysis treatment of an acute or chronic kidney ailment, which may include the supportive use of an artificial kidney machine.

After you receive appropriate training at a Network dialysis Facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We will determine if equipment is made available on a rental or purchase basis. At our option, we may Authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a Provider we Authorize before the purchase.

Durable Medical Equipment (DME), Devices and Supplies

The supplies, equipment and appliances described below are Covered Services when Medically Necessary and received by a Network Provider under this benefit. If the supplies, equipment and appliances include comfort, luxury or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose and is Medically Necessary. Any expense that exceeds the maximum Allowed Amount for the standard item which is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition. Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, when Prior Authorization is approved by us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

1. The equipment, supply or appliance is a Covered Service;

2. The continued use of the item is Medically Necessary; and
3. There is reasonable justification for the repair, adjustment or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1. The equipment, supply or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by our Durable Medical Equipment vendor should be done to estimate the cost of repair.
3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth or deterioration of function, etc.
4. The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

1. Repair and replacement due to misuse, malicious breakage or gross neglect.
2. Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliance described below.

Disposable Medical Supplies: Disposable medical supplies, which have a primary medical purpose, are covered and are subject to reasonable quantity limits as determined by us. Examples include, but are not limited to: bandages and wraps, gloves, suction catheters, Surgical sponges, hypodermic needles, syringes, and applicators. The supplies are subject to the Member's medical Deductible Amount, Copayment Amount and Coinsurance Amount.

Durable Medical Equipment: Durable Medical Equipment is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and used in the Member's home. Durable Medical Equipment includes: standard Hospital beds, standard non-motorized wheelchairs, wheelchair cushion, standard walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen and oxygen equipment. Durable Medical Equipment and supplies are subject to Prior Authorization as outlined in this Contract. Please see your Schedule of Benefits for benefit levels or additional limits. We will determine if equipment is made available on a rental or purchase basis. At our option, we may Authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a Provider we Authorize before the purchase.

Covered Services may include, but are not limited to:

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for IV fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.

7. Cardiac, neonatal and sleep apnea monitors.
8. Augmentative communication devices are covered when we approve based on the Member's condition.
9. Rental of one Continuous Passive Motion (CPM) machine per Member following a covered joint Surgery.

Exclusions:

Non-covered items may include but are not limited to:

1. Air conditioners.
2. Ice bags/coldpack pump.
3. Raised toilet seats.
4. Rental of equipment if the Member is in a Facility that is expected to provide such equipment.
5. Trans-lift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.

Orthotic Devices: Orthotic Devices, which are attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function. Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent or correct deformities, or to improve the function of movable parts of the body or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an Orthotic Device is billed with it, but not if billed separately.

Covered Orthotic Devices may include, but are not limited to, the following:

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity)S
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Medically Necessary corrective footwear, including custom made shoe inserts, Prior Authorization may be required.
10. Devices for correction of positional plagiocephaly.
11. Orthopedic shoes.

12. Standard elastic stockings.

Orthotic Devices may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members when Medically Necessary or for any Member when an appliance is damaged and cannot be repaired.

Exclusions: Orthopedic shoes that are not attached to an appliance; arch supports, including custom shoe modifications or inserts and their fittings.

Ostomy Supplies: Ostomy supplies for the removal of bodily secretions or waste through an artificial opening. Quantities that are greater than CMS guidelines may require Prior Authorization by us.

Prosthetic Devices: Prosthetic Devices are items which replace all or part of an external body part, or function thereof. Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of Prosthetic Devices and supplies that:

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

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

Covered Services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four Surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic Devices, if any, do not apply.
4. Artificial eyes or larynx, breast prosthesis, or basic artificial limbs. If more than one Prosthetic Device can meet a Member's functional needs, only the charge for the most cost-effective Prosthetic Device will be considered a Covered Service.
5. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
6. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract Surgery or injury; the first pair of contact lenses or eyeglasses are

covered. The donor lens inserted at the time of Surgery are not considered contact lenses and are not considered the first lens following Surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.

7. Colostomy and other ostomy (Surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (not to exceed one per calendar Year) when purchased through a Network Provider. This coverage is only provided for Members who suffer from hair loss as a result of an underlying medical condition, treatment or injury. Coverage shall be subject to a written recommendation by the treating Physician stating that the wig is Medically Necessary.

When Authorized in advance, repair, adjustment or replacement of appliances and equipment is covered.

Exclusions: take-home dressings and supplies following hospitalization; any other supplies, dressings, appliances, devices or services which are not specifically listed as covered above; replacement or repair of appliances, devices and supplies due to loss, breakage from willful damage, neglect or wrongful use, or due to personal preference. Dentures, replacing teeth or structures directly supporting teeth, Dental appliances, such as non-rigid appliances, garter belts, arch supports and corsets, and wigs (except as described above) when purchased through a Non-Network Provider. Penile prosthesis when medical necessity criteria are not met or is strictly a cosmetic procedure.

If you have questions regarding what Covered Services and supplies are covered, call Member Services for assistance.

Emergency Services

If you experience an Emergency Medical Condition, you should call 911, or go to the nearest emergency room. For a Behavioral Health crisis, call or text 988. We cover Emergency Services both in and out of our Service Area, including outside of the United States. We cover these services 24 hours a day, seven days a week. Please also refer to the Foreign Claims Incurred For Emergency Care provision for more details.

Covered Service and supply expenses for an Emergency Medical Condition or Emergency Services for Behavioral Health include the following:

1. Emergency Services necessary to screen and Stabilize a Member if a prudent layperson acting reasonably would have believed that an Emergency Medical Condition existed;
2. Ambulance services to an emergency room and treatment provided as part of the ambulance service;
3. Emergency room services and supplies and treatment, including professional charges, Facility charges, outpatient charges for patient observation and medical screening examinations required for the stabilization of a Member experiencing an Emergency

Medical Condition and treatment of an injury or illness, even if confinement is not required;

4. Further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, and necessary in order to Medically Stabilize the patient;
5. Services provided by staff or Facilities of a Hospital or Behavioral Health Emergency Services Provider after the Member is Stabilized and as part of outpatient observation or an Inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished; and
6. Prescription medications associated with an emergency, including those purchased in a foreign country.

Prior Authorization of emergency medical services will not be required prior to the point that the Member is Stabilized. Notification of an Inpatient admission must be submitted to us within one business day following admission or as soon as reasonably possible.

Emergency Services received from Non-Network Providers are covered as follows under the Balance Billing Protection Act or the federal No Surprises Act for services outside of Washington State:

1. Emergency Services from a Non-Network Provider or Facility in Washington: Prior to July 1, 2023, we will determine a commercially reasonable Allowed Amount based on payments for the same or similar services provided in a similar geographic area. The Washington State Insurance Commissioner may extend this date. The Member's Cost Sharing responsibility will be determined using our median Network contracted rate for the same or similar service in the same or similar geographical area. Unless extended by the Insurance Commissioner, we will pay Claims incurred on or after July 1, 2023 based on the federal requirements under the No Surprises Act. Member Cost Share will be calculated based on the recognized amount outlined in the No Surprises Act. *Non-Network Providers in Washington State cannot Balance Bill you for Emergency Services.
2. Emergency Services from a Non-Network Provider or Facility outside of Washington: We pay based on the federal requirements under the No Surprises Act, unless a negotiated fee that has been mutually agreed upon by us and the Provider or Facility, along with any Network Member Cost Sharing amount, has been accepted as payment in full. If a negotiated fee is not mutually agreed to by us and the Provider or Facility, the Non-Network Providers or Facilities may not Balance Bill you for Emergency Services, and the Member's Cost Sharing responsibility will be calculated based on the recognized amount outlined in the No Surprises Act. If you are Balance Billed in these situations, please contact Member Services immediately at the number listed on the back of your Member identification card.
3. Emergency Transport: Payment for ground emergency transport within the Service Area provided by non-network ambulances will be based on the following until December 31, 2027:
    a. The rate established by the local governmental entity where the Covered Service originated for the provision of ground ambulance services by Ground Ambulance

Services Organizations owned and operated by the local governmental entity and submitted to the Office of the Insurance Commissioner (OIC);

b. Where the ground ambulance service was provided by a private Ground Ambulance Services Organization under contract with the local governmental entity where the Covered Service originated, the amount set by the contract and submitted to the OIC; or

c. If a rate has not been established or contracted as described above, the rate will be the lesser of:

   i. 325 percent of the current published rate for ambulance services as established by the Centers for Medicare and Medicaid Services (CMS) for the same service provided in the same geographic area; or

   ii. The Ground Ambulance Services Organization's billed charges.

Payment for emergency air ambulance services within the Service Area provided by non-network ambulances will be based on the federal requirements under the federal No Surprises Act. Member Cost Share will be calculated based on the recognized amount outlined in the federal No Surprises Act.

Payment for emergency transportation outside of the Service Area will be based on the federal requirements under the federal No Surprises Act. Member Cost Share will be calculated based on the recognized amount outlined in the federal No Surprises Act.

Family Planning and Contraception Services

Family planning and contraception benefits are covered under preventive care, without Cost Sharing when provided by a Network Provider and the care is legal under Applicable Law. These benefits include the following for adolescent and adult Members, in accordance with the most recent guidelines supported by the Health Resources and Services Administration (HRSA):

1. The full range of contraceptives currently identified by the FDA, including:
   a. Sterilization Surgery;
   b. Implantable rods
   c. Copper intrauterine devices;
   d. Intrauterine devices with progestin (all durations and doses), including insertion and removal;
   e. Injectable contraceptives
   f. Oral contraceptives (combined pill),
   g. Oral contraceptives (progestin only),
   h. Oral contraceptives (extended or continuous use)
   i. The contraceptive patch
   j. Vaginal contraceptive rings

k. Diaphragms
l. Contraceptive sponges
m. Cervical caps
n. Condoms
o. Spermicides
p. Emergency contraception (levonorgestrel) and
q. Emergency contraception (ulipristal acetate)

Please refer to the most current Formulary/Prescription Drug List (PDL) for a complete list of Prescription Drug contraceptives available to you on our website at ambetter.coordinatedcarehealth.com/provider-resources/pharmacy.html.

Please follow the steps below for reimbursement:

a. For contraceptives purchased at a Network pharmacy, the pharmacy will submit the Claim to us on your behalf.
b. If you purchase contraceptives from a non-network pharmacy, please fill out and submit the "Prescription Claim Reimbursement Form" available on our website at ambetter.coordinatedcarehealth.com/resources/handbooks-forms.html. The form contains submission instructions.
c. If contraceptives are purchased from a business other than a pharmacy or medical Facility, please fill out and submit the "Member Reimbursement Medical Claim Form" available on our website at the address listed above. The form contains submission instructions.

2. For contraceptive drugs, a 12-month supply may be obtained at one time by the Member, unless the Member requests a smaller supply or the prescribing Provider instructs that the Member must receive a smaller supply. Members may receive contraceptive drugs on site at the Provider's office, if available.
3. Coverage is also available for any additional contraceptives approved, granted, or cleared by the FDA (if the patient and the patient's attending provider have determined it to be medically appropriate).
4. Contraceptive care, such as: screening, education, provision of contraception, counseling and follow-up care (e.g., management, evaluation and changes, including the removal, continuation and discontinuation of contraceptives).
5. Instruction in fertility awareness-based methods, including lactation amenorrhea.

Note: The following requirements must be met for prescription birth control to be covered at 100 percent:

1. the drug is generic; or
2. the drug is a Brand Name Drug and
    a. a generic version is not available or

b. the generic version is medically inappropriate, as determined by your health care Provider.

Note: Services that are integral to the furnishing of the above-listed preventive care coverage (e.g., anesthesia provided during sterilization Surgery or ultrasound during intrauterine device removal), are also included under preventive care, regardless of whether the service is billed separately.

Note: We are committed to providing coverage regardless of race, color, national origin, age, disability, sex, gender identity or sexual orientation, and we will not issue any automatic initial denials of coverage for reproductive health care services that are ordinarily or exclusively available to individuals of one gender, based on the fact that the individual's gender assigned at birth, gender identity, or gender otherwise recorded in one or more government-issued documents, is different from the one to which such health services are ordinarily or exclusively available.

Exclusion: We will not cover Prescription Drug contraceptive refills that are obtained in the last quarter of the calendar year if a 12-month supply of the contraceptive drug was dispensed earlier during the calendar year.

However, this exclusion will not apply to new prescriptions for a different contraceptive drug received during the last quarter of the calendar year, even if a 12-month supply of a contraceptive drug was previously obtained.

Fertility Preservation

Medically Necessary services and supplies for standard fertility preservation treatments are covered when a cancer treatment may directly or indirectly cause iatrogenic infertility. Iatrogenic infertility is infertility that is caused by a medical intervention, including reactions from prescribed drugs or from medical or Surgical Procedures that may be provided for cancer treatment. Prior Authorization may be required.

Gender Affirming Treatment

Covered Services for Medically Necessary Gender Affirming Treatment include facial feminization and other surgeries or treatment to support transition due to gender dysphoria, if such services are prescribed in accordance with Generally Accepted Standards of Medical Practice.

For additional information regarding our clinical policy for Gender Affirming Treatment, please refer to our website at AmbetterHealth.com/en/WA or contact Member Services to request a paper copy of the policy.

Habilitation, Rehabilitation Facility and Extended Care Facility Benefits

Covered Services and supplies include Medically Necessary Habilitation or Rehabilitation services on an Inpatient or outpatient basis when rendered by a Network Provider. Habilitative and rehabilitative services include:

1. Inpatient Rehabilitation Facility, Extended Care Facility and professional services delivered in those Facilities including daily room and board, nursing services, diagnostic testing, x-rays and laboratory services, and prescriptions filled in the Facility;
2. Outpatient physical therapy, occupational therapy, massage therapy, speech therapy and aural therapy;
3. Braces, splints, prostheses, orthopedic appliances and Orthotic Devices, supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts;
4. Durable Medical Equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax; and
5. Neurodevelopmental therapy, consisting of physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay.

Habilitative services and devices received that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and outpatient settings. We will not cover habilitative devices that do not require FDA-approval and a prescription in order to dispense.

See your Schedule of Benefits for benefit levels or additional limits. **Note:** Benefits for cardiac therapy, pulmonary therapy and respiratory therapy are not subject to the benefit limitation indicated on your Schedule of Benefits.

Care ceases to be Rehabilitative upon our determination of any of the following:

1. The Member has reached Maximum Therapeutic Benefit.
2. Further treatment cannot restore bodily function beyond the level the Member already possesses.
3. There is no measurable progress toward documented goals.
4. Care is primarily Custodial Care.
5. When Rehabilitation services are Medically Necessary for the treatment of cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases.

Hearing Benefits

Coverage is provided for an annual hearing examination and hearing aids, including cochlear implants and bone anchored hearing aids. Coverage includes the initial assessment, fitting, adjustment, auditory training and ear molds as necessary to maintain optimal fit. Coverage includes services for Members who have already obtained any hearing aid (including an over-the-counter hearing aid) or intend to obtain hearing aids. Coverage for hearing aids is limited to one hearing aid per ear every three years.

Prior Authorization may be required, see your Schedule of Benefits for details.

Home Health Care Service Benefits

Covered Services and supplies for Home Health Care provided by a license Home Health Care Agency as an alternative to hospitalization or institutionalization. Coverage is provided for Medically Necessary care provided by a Network Provider at the Member's home when provided under a treatment plan approved by the Member's Physician and includes the following:

1. Home Health Aide Services.
2. Skilled nursing services.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for Home Health Care.
4. Intravenous (I.V.) medication and pain medication are Covered Services to the extent they would have been Covered Services during an Inpatient Hospital stay.
5. Medically Necessary supplies.
6. Rental or purchase of Medically Necessary Durable Medical Equipment at the discretion of the plan. At our option, we may Authorize the purchase of the equipment from a Network Provider in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we Authorize before the purchase.

Home Health Care services and benefits are subject to Prior Authorization requirements as outlined in this Contract. For additional information on included benefits please see the **Ambulatory Patient Services** and **Habilitation, Rehabilitation Facility and Extended Care Facility Benefits** provisions.

Limitations:

See your Schedule of Benefits for annual visit limits for services provided by Home Health Care Agencies.

Exclusion:

No benefits will be payable for charges related to Respite Care, Custodial Care, or educational care except as covered under this provision or the Hospice Care Service Benefits provision.

Hospice Care Service Benefits

This provision only applies to a Terminally Ill Member receiving Medically Necessary care under a Hospice care program or in a home setting. Respite Care is covered on an Inpatient or home basis to allow temporary relief to family members from the duties of caring for a Member who is undergoing Hospice care. Respite days that are applied toward the Member's Deductible Amount are considered benefits provided and shall apply against any maximum benefit limit for these services. See your Schedule of Benefits for coverage limits.

The list of Covered Services include:

1. Room and board in a Hospice while the Member is an Inpatient.
2. Occupational therapy.
3. Speech-language therapy.

4. The rental of medical equipment while the Terminally Ill Member is in a Hospice care program to the extent that these items would have been covered under the Contract if the Member had been confined in a Hospital.
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the Member regarding the Member's terminal illness.
7. Terminal Illness Counseling of the Member's Immediate Family.
8. Bereavement Counseling.

For each calendar day the Member is confined in a Hospice, benefits for room and board will not exceed the most common semiprivate room rate of the Hospital or nursing home with which the Hospice is associated. Benefits for Hospice Inpatient, home and outpatient care is subject to Prior Authorization as outlined in this Contract.

Exclusions and Limitations:

1. Any exclusion or limitation contained in the Contract regarding:
2. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a Hospice care program; or
3. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Hospital Services

Covered Service and supply expenses are limited to charges made by a Network Hospital for:

1. Daily room and board and nursing services, not to exceed the Hospital's most common semi-private room rate.
2. A private Hospital room when needed for isolation.
3. Daily room and board and nursing services while confined in an Intensive Care Unit.
4. Skilled Nursing Facility costs, including professional services and pharmacy services and prescriptions filled in the Skilled Nursing Facility pharmacy. Skilled Nursing Facility Inpatient days for illness, injury or physical disability are limited to 60 calendar days per calendar year.
5. Inpatient use of an operating, treatment, or recovery room.
6. Outpatient use of an operating, treatment, or recovery room for Surgery.
7. Services and supplies, including drugs and medicines, which are routinely provided by the Hospital for use only while you have Inpatient status.
8. Emergency treatment of an injury or illness, even if confinement is not required. See your Schedule of Benefits for limitations.

Expenses for these services and supplies are covered if Medically Necessary and may be subject to Prior Authorization. Please see your Schedule of Benefits for more information regarding services that require Prior Authorization and specific benefit limits, day or visit, if any.

Long Term Acute Care (LTACH)

Long-term acute care Hospitals (LTACHs) furnish extended medical and rehabilitative care to individuals with clinically complex problems, such as multiple acute or chronic conditions, that need Hospital-level care for relatively extended periods. LTACH benefits are subject to Prior Authorization requirements as outlined in this Contract.

Common conditions/services that may be considered Medically Necessary for LTACH level of care include, but are not limited to:

1. Complex wound care:
    a. Daily Physician monitoring of wound
    b. Wound requiring frequent complicated dressing changes and possible repeated debridement of necrotic tissue
    c. Large wound with possible delayed closure, draining, and/or tunneling or high output fistulas
    d. Lower extremity wound with severe ischemia
    e. Skin flaps and grafts requiring frequent monitoring
2. Infectious disease:
    a. Parenteral anti-infective agent(s) with adjustments in dose
    b. Intensive sepsis management
    c. Common conditions include osteomyelitis, cellulitis, bacteremia, endocarditis, peritonitis, meningitis/encephalitis, abscess and wound infections
3. Medical complexity:
    a. Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment
    b. Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease, and malignant/end-stage disease
4. Rehabilitation:
    a. Care needs cannot be met in a Rehabilitation or Skilled Nursing Facility
    b. Patient has a comorbidity requiring acute care
    c. Patient is able to participate in a goal-oriented Rehabilitation plan of care
    d. Common conditions include CNS conditions with functional limitations, debilitation, amputation, cardiac disease, orthopedic Surgery
5. Mechanical ventilator support:
    a. Failed weaning attempts at an acute care Facility
    b. Patient has received mechanical ventilation for 21 consecutive days for six hours or more per day

c. Ventilator management required at least every four hours as well as appropriate diagnostic services and assessments
d. Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions
e. Patient is hemodynamically stable and not dependent on vasopressors
f. Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60 percent or less with O2 saturation at least 90 percent
g. Common conditions include complications of acute lung injury, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders
h. Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

Infertility Treatment Benefits

Coverage is provided for counseling, planning services, evaluations and testing to diagnose infertility in a covered Member when provided by a Network Provider. Preliminary infertility evaluation and diagnosis are covered and may be required prior to receiving the artificial insemination benefits. Infertility benefits include artificial insemination in vivo procedures; placement of sperm into the cervix or uterus to achieve a Pregnancy; and simple sperm preparation such as sperm washing and isolation.

Exclusions:

All services and supplies (other than artificial insemination) related to conception by artificial means. Prescription Drugs related to such services, and donor semen and donor eggs used for such services, such as, but not limited to in vitro fertilization, ovum transplants, gamete intra fallopian transfer and zygote intra fallopian transfer. In addition, donor sperm or eggs, or services related to procuring or storing these materials are not covered. These exclusions apply to fertile as well as infertile individuals or couples.

Lymphedema Benefit

Treatment of lymphedema is covered when rendered or prescribed by a licensed Physician or received in a Hospital or other public or private Facility authorized to provide lymphedema treatment. Coverage includes multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

Mammograms

Covered Service and supply expenses will be provided for routine screenings, Medically Necessary supplemental breast examinations and diagnostic breast examinations. Routine screenings will be provided for breast cancer and will be provided at the following intervals when obtained from a Network Provider: One baseline breast cancer screening mammography for a Member between the ages of 35 and 40 years. If the Member is less than 40 years of age and at risk, one breast cancer screening mammography performed every year. If the Member

is at least 40 years of age, one breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Benefits for Medically Necessary mammography screenings, diagnostic and supplemental mammography, which include digital breast tomosynthesis (3D mammography) breast magnetic resonance imaging, breast ultrasounds and pathology evaluations are provided in accordance with the recommendations established by the United States Preventive Services Task Force. Please refer to the **Preventive Care Benefits** provision. Medically Necessary supplemental and diagnostic mammography and mammography screenings are covered without Member Cost Share (i.e., covered in full without Deductible Amount, Copayment Amount or Coinsurance Amount) when obtained from a Network Provider.

For purposes of this provision:

"**Diagnostic breast examination**" means a Medically Necessary and appropriate examination of the breast, including an examination using diagnostic mammography, digital breast tomosynthesis, also called three-dimensional mammography, breast magnetic resonance imaging or breast ultrasound that is used to evaluate an abnormality:

1. Seen or suspected from a screening examination for breast cancer; or
2. Detected by another means of examination.

"**Supplemental breast examination**" means a Medically Necessary and appropriate examination of the breast, including an examination using breast magnetic resonance imaging or breast ultrasound that is:

1. Used to screen for breast cancer when there is no abnormality seen or suspected; and
2. Based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

Mastectomy and Breast Reconstruction

Covered Services and supplies when rendered by a Network Provider include charges for reconstructive breast Surgery and associated procedures, including internal breast prostheses, as a result of a partial or total mastectomy which resulted from illness or injury regardless of when the mastectomy was performed. Coverage includes Surgery and all stages of reconstruction of the diseased and non-diseased breast and Prosthetic Devices necessary to restore a symmetrical appearance. Complications of mastectomy services including lymphedema are covered for any Member who has undergone a mastectomy. Covered Services and supplies include four Surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act.

Exclusion: cosmetic services, including treatment for complications resulting from cosmetic Surgery unless for the Medically Necessary treatment of Gender Dysphoria, and complications of non-covered Surgical Services.

Medical and Surgical Services

Covered Services provided under this provision are subject to all other terms and conditions of the Contract, including the Deductible Amount and Cost Sharing requirements. Covered

Services may also be subject to Prior Authorizations and include, but are not limited to, the following services:

1. For Surgery in a Physician's or Medical Practitioner's office, in an Inpatient Facility, an outpatient Facility or at an Ambulatory Surgery Center, including services and supplies.
2. For pre-surgical and post-surgical procedures and testing, including but not limited to, diagnostic services using radiological, ultrasonographic or laboratory services:
    a. Laboratory tests or radiological examinations done on an outpatient basis in a Hospital or other Facility accepted by the Hospital before Hospital confinement or outpatient Surgery or procedures. The tests must be for the same bodily Illness or Injury causing the Member to be hospitalized or to have the outpatient Surgery or procedure.
    b. Bone density studies
    c. Clinical laboratory tests
    d. Gastrointestinal laboratory procedures
    e. Pulmonary function tests
    f. Genetic testing
    g. For Medically Necessary genetic or molecular cancer testing, including but not limited to, tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomics testing, whole exome, genome sequencing and biomarker testing
3. For medical services in an office or Facility that is provided by a licensed Medical Practitioner or Specialist Provider, including consultation and Surgery-related services.
4. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy and radiation therapy or treatment in a Hospital or office setting.
5. For Durable Medical Equipment, Prosthetic Devices, Orthotic Devices or other Necessary Medical Supplies following a medical or Surgical procedure such as crutches, orthopedic splints, braces or casts. Please see the **Durable Medical Equipment** provision of this Contract.
6. For hemodialysis and the charges by a Hospital or Facility for the processing and administration of genetic testing, blood or blood components, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for you.
7. For the cost and administration of anesthesia, oxygen, drugs, medications and biologicals.
8. For Medically Necessary reconstructive or cosmetic Surgery including, but not limited to:
    a. Reconstructive breast Surgery charges as a result of a partial or total mastectomy. Coverage includes Surgery and reconstruction of the diseases and non-diseased breast and Prosthetic Devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedema.

b. Reconstructive Surgery for craniofacial abnormalities.

9. For Medically Necessary dental Surgery due to:
    a. An accidental Injury which results in damage to natural teeth. Injury to the natural teeth will not include Injury as a result of chewing.
    b. Surgery to correct a functional defect which results from a congenital and/or acquired disease or anomaly.
    c. Cleft lip and cleft palate for an eligible Member. Covered Services include medical, dental, speech therapy, audiology and nutrition services only if such services are prescribed by the treating Physician or surgeon and such Physician or Surgeon certifies that such services are Medically Necessary and consequent to treatment of the cleft lip or cleft palate.
    d. Dental anesthesia charges include coverage for the administration of general anesthesia and Hospital charges for dental care, rendered by a dentist, provided to the following Members:
        i. A Member whose treating Medical Practitioner in consultation with the dentist determines the Member has a significantly complex dental condition or a developmental disability in which patient management in the dental office proved to be ineffective; or
        ii. A Member who has one or more medical conditions that would create significant or undue medical risk for the Member during delivery of any dental treatment or Surgery if not rendered in a Hospital or Ambulatory Surgical Center.
        iii. Necessary dental treatment is that which, if left untreated, is likely to result in a medical condition. Use of general anesthesia in a Hospital or Ambulatory Surgical Center is subject to Prior Authorization. Please call Member Services to confirm your benefits for the use of general anesthesia in a Hospital or Ambulatory Surgical Center.
10. For the treatment of breast cancer by dose-intensive chemotherapy bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy bone marrow transplant or stem cell transplants.
11. For routine patient care for Members enrolled in an eligible cancer trial that is deemed an Experimental or Investigational treatment if the services provided are otherwise considered Covered Services under this Contract. See the **Clinical Trial** provision of this Contract.
12. Urgent Care Center visits, including Provider services, Facility costs and supplies.
13. For the following types of Medically Necessary implants and tissue grafts:
    a. Cornea transplants;
    b. Artery or vein grafts;
    c. Heart valve grafts;

d. Prosthetic tissue replacement, including joint replacements;

e. Implantable prosthetic lenses, in connection with cataracts;

f. Skin grafts

14. For X-rays, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT) and other diagnostic services. See **Radiology, Imaging and Other Diagnostic Testing** provision of this Contract.
15. For Medically Necessary services for complications arising from medical and Surgical conditions.
16. For respiratory, pulmonary, cardiac, physical, occupational and speech therapy services. Please see **Habilitation, Rehabilitation Facility and Extended Care Facility Benefits** provision of this Contract.
17. For occupational therapy following a covered treatment for traumatic hand injuries.
18. For children's early intervention therapy for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists and clinical social workers working with children from birth to 36 months of age with an identified developmental disability and/or delay;
19. For Medically Necessary footcare treatment that may require Surgery; Prior Authorization may be required.
20. For Medically Necessary nutritional counseling; Prior Authorization may be required.
21. For dermatology services which are limited to the following: Medically Necessary minor Surgery, tests and office visits provided by a dermatologist who is a Network Provider.
22. For Medically Necessary biofeedback services.
23. For services associated with human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation.
24. For Medically Necessary Chiropractic Care or manipulative therapy treatment on an outpatient basis only.
25. For all Medically Necessary immunizations, monitoring screenings, re-screenings and laboratory testing for a newborn in the early detection, diagnosis and intervention of a condition or disorder. This also includes, but not limited to, hearing or audiological services, follow-up examinations and pulse oximetry.
26. For Medically Necessary allergy testing, including allergy injections and serum.
27. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
28. Medically Necessary genetic blood tests. This does not include genetic testing of a dependent child's father.
29. Services and supplies related to sexual reassignment Surgery when found to be Medically Necessary.

30. Blood, blood products, and storage, including the services and supplies from a blood bank.
31. For elective sterilization procedures (e.g., vasectomies, tubal ligation). **Note:** No Cost Share applies.

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

Medical Dental Services – General Anesthesia and Facility Charges

Covered Services and supplies are provided for general anesthesia services and related Facility charges in conjunction with any dental procedure performed at a Network Hospital or Ambulatory Surgical Center if such anesthesia services and related Facility charges are Medically Necessary because the Member:

1. Is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
2. Has a medical condition that the Member's Physician determines would place the person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the Member's Physician.

Except as outlined in this provision, no additional Coverage is provided for Dental Services under this Contract.

Medical Foods

We cover medical foods and formulas for:

1. Outpatient total parenteral nutritional therapy;
2. Outpatient elemental formulas for malabsorption; and
3. Dietary formula when Medically Necessary for the treatment of:
    a. Phenylketonuria (PKU);
    b. Eosinophilic gastrointestinal associated disorders; and
    c. Inborn errors of metabolism.

Equipment and supplies for the administration of enteral and parenteral therapy are covered under **Durable Medical Equipment (DME), Devices and Supplies** provision.

In addition, Inpatient and outpatient benefits will be provided for Medically Necessary donor human milk when ordered by a licensed health care provider with prescriptive authority or an international board certified lactation consultant certified by the International Board of Lactation Consultant Examiners if the infant meets at least one of the following criteria, including but not limited to:

1. An infant birth weight of below 2,500 grams;
2. An infant gestational age equal to or less than 34 weeks;
3. Infant hypoglycemia;

4. A high risk for development of necrotizing enterocolitis, bronchopulmonary dysplasia, or retinopathy of prematurity;
5. A congenital or acquired gastrointestinal condition with long-term feeding or malabsorption complications;
6. Congenital heart disease requiring Surgery in the first year of life;
7. An organ or bone marrow transplant;
8. Sepsis;
9. Congenital hypotonias associated with feeding difficulty or malabsorption;
10. Renal disease requiring dialysis in the first year of life;
11. Craniofacial anomalies;
12. An immunologic deficiency;
13. Neonatal abstinence syndrome;
14. Any other serious congenital or acquired condition for which the use of pasteurized donor human milk and donor human milk derived products is medically necessary and supports the treatment and recovery of the child; or
15. Any baby still Inpatient within 72 hours of birth without sufficient human milk available.

Inpatient benefits are covered without Member Cost Share (i.e., covered in full without Deductible Amount, Copayment Amount or Coinsurance Amount) when obtained from a Network Provider. Outpatient benefits are subject to the Durable Medical Equipment Cost Share amounts.

The prescription must state that the infant is either:

1. Medically or physically unable to receive maternal human milk or participate in breastfeeding, or
2. The infant's mother is medically or physically unable to produce maternal human milk in sufficient quantities, caloric density or participate in breastfeeding.

Low-Protein Food Products for Treating Inherited Metabolic Diseases

Low-protein food products for treating certain inherited metabolic disease are covered. Inherited metabolic diseases are diseases caused by an inherited abnormality of body chemistry. Low-protein food products are foods that are especially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease. Low protein food products do not include natural foods that are naturally low in protein.

Benefits for low-protein food products are limited to treating the following diseases:

1. Phenylketonuria (PKU)
2. Maple Syrup Urine Disease (MSUD)
3. Methylmalonic Acidemia (MMA)
4. Isovaleric Acidemia (IVA)

5. Propionic Acidemia
6. Glutaric Acidemia
7. Urea Cycle Defects
8. Tyrosinemia

Exclusions: any other non-medical dietary formulas, oral nutritional supplements, special diets, prepared foods/meals and formula for access problems.

Medical Vision Services

Covered Services include vision screenings to diagnose and treat a suspected disease or injury of the eye.

Vision services under the medical portion of your Contract do not include:

1. Referrals to a specialist for evaluation and diagnosis of refractive error, including presbyopia.
2. Eye examinations required by an employer or as a condition of employment.
3. Radial keratotomy, LASIK and other refractive eye Surgery.
4. Services or materials provided as a result of any workers' compensation law or required by any governmental agency.
5. Orthoptics, vision training or subnormal vision aids.

Mental Health and Substance Use Disorder Benefits

The coverage described below is designed to comply with requirements under the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Covered Services will be provided on an Inpatient and outpatient basis for the treatment of Mental Health Disorder and Substance Use Disorder diagnoses. These conditions affect the individual's ability to cope with the requirements of daily living. If you need mental health and/or Substance Use Disorder treatment, you may choose any Provider participating in our Behavioral Health Network. Deductible Amounts, Copayment or Coinsurance Amounts and treatment limits for covered mental health and Substance Use Disorder benefits will be applied in the same manner as physical health service benefits.

Covered Services for Mental Health Disorders and Substance Use Disorders are included on a non-discriminatory basis for all Members for the diagnosis and Medically Necessary treatment of mental, emotional or Substance Use Disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association or the International Statistical Classification of Diseases and Related Health Problems (ICD).

When making coverage determinations, our Behavioral Health Utilization Management staff utilizes established level of care guidelines and medical necessity criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. Our Behavioral Health staff utilize Change Healthcare InterQual® criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for Substance Use Disorder determinations. Services should always be provided in the least

restrictive clinically appropriate setting. Any determination that requested services are not Medically Necessary will be made by a qualified licensed mental health professional.

Coverage for Inpatient or residential Substance Use Disorder treatment by a Behavioral Health agency will be provided for at least two business days excluding weekends and holidays prior to Utilization Review of the services by our staff. Coverage will be provided for no less than 14 calendar days from the date the Member was admitted to the Behavioral Health agency for the initial Authorization approved by us. Subsequent Authorizations approved by us will be provided for no less than seven calendar days prior to requiring additional Utilization Review by our staff.

Coverage will be provided for no less than three calendar days for Substance Use Disorder withdrawal management services in a Behavioral Health agency prior to Utilization Review by our staff.

Covered Inpatient and outpatient mental health and/or Substance Use Disorder services are as follows:

Inpatient

1. Inpatient Psychiatric Hospitalization;
2. Inpatient Detoxification Treatment;
3. Inpatient Substance Use Disorder withdrawal Treatment;
4. Inpatient Rehabilitation;
5. Crisis Stabilization;
6. Residential Treatment Facility for mental health and Substance Use Disorders; and
7. Electroconvulsive Therapy (ECT).

Outpatient

1. Partial Hospitalization Program (PHP);
2. Intensive Outpatient Program (IOP);
3. Mental Health Day treatment;
4. Outpatient Substance Use Disorder withdrawal programs;
5. Evaluation and assessment for mental health and Substance Use Disorders;
6. Individual and group therapy for mental health and Substance Use Disorders;
7. Medication Assisted Treatment - combines Behavioral Health therapy and medications to treat Substance Use Disorders;
8. Medication management services;
9. Psychological and neuropsychological testing and assessment;
10. Applied Behavior Analysis;
11. Covered Services provided through Telemedicine or Virtual 24/7 Care benefits (individual/family therapy; medication monitoring; assessment and evaluation);

12. Electroconvulsive Therapy (ECT); and
13. Transcranial Magnetic Stimulation (TMS).

Expenses for these services are covered if Medically Necessary and may be subject to Prior Authorization. However, we will not require Prior Authorization for withdrawal management services Inpatient or residential Substance Use Disorder treatment services. Please see your Schedule of Benefits for more information regarding services that require Prior Authorization.

In addition, Integrated Care Management is available for all of your health care needs, including Behavioral Health. Please call Member Services to be referred to a care manager for an assessment.

Pediatric Vision Benefits – Children under the age of 19

Coverage for vision services is provided for an Eligible Child, under the age of 19 through the end of the plan year in which they turn 19 years of age:

1. Routine ophthalmological examination;
2. Comprehensive eye examination, including dilation and with refraction every calendar year;
3. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) in glass or plastic, or initial supply of Medically Necessary contacts every calendar year;
4. One pair of prescription standard frames per calendar year; and
5. Low vision evaluation and aids.

Please refer to your Schedule of Benefits for a detailed list of Member Cost Sharing, annual maximum and appropriate service limitations. To see which vision providers are part of the Network, please visit AmbetterHealth.com/en/WA or call Member Services.

Eyeglasses

Covered Service and supply expenses for lenses include single vision, lined bifocal, lined trifocal, or lenticular, in glass or plastic. If you require a more complex prescription lens, contact Member Services for Prior Authorization.

The following additional lens options (including coating and tints) are covered:

1. Progressive lenses (standard or premium);
2. Intermediate vision lenses;
3. Blended segment lenses;
4. Hi-Index lenses;
5. Plastic photosensitive lenses;
6. Photochromic glass lenses;
7. Glass-grey #3 prescription sunglass lenses;
8. Fashion and gradient tinting;

9. Ultraviolet protective coating;
10. Polarized lenses;
11. Scratch resistant coating;
12. Anti-reflective coating (standard, premium or ultra);
13. Oversized lenses;
14. Polycarbonate lenses; and
15. High power spectacles, magnifiers and telescopes.

Coverage includes one eyeglass frame per calendar year. Members are able to choose from a selection of eyeglass frames in a variety of sizes and colors.

Contact Lenses

Contact lenses are covered once every calendar year in lieu of the eyeglasses and frame benefits. The benefit includes contact lens evaluation, fitting, and follow-up care. If determined to be Medically Necessary, contact lenses will be covered in lieu of eyeglasses at a minimum for the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

To see which vision Providers are part of the Network, please visit AmbetterHealth.com/en/WA or call Member Services.

Covered Services and supplies for non-routine vision services include eye examinations for the treatment of medical conditions of the eye when the service is performed by a Network Provider (optometrist or ophthalmologist). Covered Services and supplies include office visits, testing, and treatment of eye conditions producing symptoms that if left untreated may result in the loss of vision, low vision evaluation, low vision optical devices including low vision services, and training and instruction to maximize remaining usable vision as follows:

1. One comprehensive low vision evaluation every five years and low vision aids;
2. High power spectacles, magnifiers and telescopes as Medically Necessary; and
3. Follow-up care of four visits in any five-year period, if pre-authorized.

Exclusions: The following routine and non-routine vision services are excluded:

1. Deluxe frame/frame upgrade;
2. Visual therapy;
3. Two pair of glasses as a substitute for bifocals;
4. LASIK Surgery; and
5. Replacement eyewear.

Prescription Drug Benefits

We will provide coverage for Prescription Drugs when prescribed by a licensed Provider and obtained at a Network pharmacy or through the mail order program. Coverage for Prescription Drugs includes generic, brand name, non-preferred and specialty drugs.

1. Generic Drug is a drug that is the pharmaceutical equivalent to one or more Brand Name Drugs. Such Generic Drugs have been approved by the FDA as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug. Generic Drugs will be dispensed whenever available. We will not require a pharmacist to dispense a brand name prescription medication when a less expensive therapeutically equivalent generic prescription medication is available.
2. Brand drug is a Prescription Drug that has been patented and is only available through one manufacturer. Preferred Brand drugs will be dispensed if there is not a generic.
3. Non-preferred drug is a Prescription Drug covered under a higher Cost Share. This tier of drug contains both Formulary Brand Name Drugs and Generic Drugs. These drugs require higher Copayment because other alternatives may be available in the lower tiers or there may be other generic equivalents available.
4. Specialty drugs are typically high-cost drugs, including but not limited to the oral, topical, inhaled, inserted or implanted, and injected routes of administration. Included characteristics of Specialty drugs are drugs that are used to treat and diagnose rare or complex diseases, require close clinical monitoring and management, frequently require special handling, and may have limited access or distribution. Specialty drugs are often also drugs that require special handling, or special or enhanced patient administration and oversight.

The appropriate drug choice for a Member is a determination that is best made by the Member and the Member's Medical Practitioner.

The drug Formulary, also known as a Prescription Drug List or PDL, is an approved list of Prescription Drugs that are covered by this Contract. The Formulary includes drugs for a variety of disease states and conditions. Periodically, the Formulary is reviewed and updated to assure that the most current and clinically appropriate drug therapies are being used. Sometimes it is Medically Necessary for a Member to use a drug that is not on the Formulary. When this occurs, the prescribing Provider may request an exception for coverage through Member Services. For a list of covered drugs please visit AmbetterHealth.com/en/WA or contact Member Services.

In addition, some of the Formulary drugs may require a Prior Authorization or step therapy requirement before coverage or may have quantity limits. See the **Prior Authorization and Step Therapy for Prescription Drugs** provision for more information. If you have questions regarding the Formulary or regarding your Prescription Drug benefits, call Member Services for assistance.

Compound Medications

Some medications that require pharmacy compounding may be covered. Compound medication that includes at least one FDA drug and is currently not FDA-approved and

available commercially in the same dosage form and strength may be covered. However, any compound medication over $100/Claim will require Prior Authorization. Specific details about which compounded medications are covered can be found by contacting Member Services.

Exception to Our Utilization Management Criteria

You or your Provider have the right to request exception to our utilization management criteria. To request exception to our Formulary utilization management criteria please follow the steps outlined under Prior Authorization and Step Therapy for Prescription Drugs provision.

Prescription Drug Cost Sharing

The Prescription Drug Cost Share amounts are shown on your Schedule of Benefits.

Prescription Maximum Out-of-Pocket means the limit or Maximum Out-of-Pocket Amount you pay for medications (during the calendar year), after you have paid your Deductible Amount and excluding any Copayment Amounts.

Prescription Copayment or Coinsurance

The applicable Copayment or Coinsurance applies to each 30 day supply. Copayment for single and multiple 30 calendar day supplies of a given prescription are payable at the time of delivery. Injectables that can be self-administered are also subject to the Prescription Drug Cost Sharing.

If the Copayment or Coinsurance Amount is greater than the actual cost of the Prescription Drug then only the actual cost will be required to be paid.

Prescription Drug Deductible Amount, if applicable, means the amount shown in the Schedule of Benefits, that must be paid during any calendar year before any Prescription Drug benefits are payable. The family Prescription Drug Deductible Amount is two times the individual Prescription Drug Deductible Amount. For family coverage, once a Member has met the individual Prescription Drug Deductible Amount, any remaining family Prescription Drug Deductible Amount can be met with the combination of any one or more Members' Eligible Expenses.

Prescription Drug Covered Services

Covered Services and supplies are limited to charges for Formulary drugs from a Network licensed pharmacy for:

1. Prescription Drugs, including off-label use of FDA-approved drugs as required by law or as expressly Authorized by us.
2. Any drug that under the laws of Washington may be dispensed only upon the written prescription of a Provider.
3. Certain preventive medications including, but not limited to, aspirin, fluoride, iron, and medications for Tobacco Use cessation, according to, and as recommended by, the United States Preventive Services Task Force, when obtained with a prescription.

4. Prescribed, anticancer medication including oral anticancer medication. All orally administered anticancer medications will be Covered on the same basis and at no greater Cost Sharing than imposed for intravenous or injected anticancer medications.
5. Diabetic supplies including insulin syringes, lancets, urine testing reagents, blood glucose monitoring reagents and insulin.
6. Prescribed medication for the treatment of hepatitis C.
7. Medically Necessary services associated with the administration of the Prescription Drug.
8. Teaching doses of self-administrable injectable medications, which are limited to three doses of medication per lifetime.
9. The total amount you will be required to pay for a covered asthma inhaler (at least one inhaled corticosteroid and at least one inhaled corticosteroid combination product) will not exceed any state and/or federal mandated limits.
10. The total amount you will be required to pay for a covered epinephrine autoinjector (at least one epinephrine autoinjector product containing at least two autoinjectors) will not exceed any state and/or federal mandated limits.
11. Prescribed HIV postexposure prophylaxis medication. **Note:** No Cost Share applies and Prior Authorization is not required for at least one covered regimen recommended by the Centers for Disease Control and Prevention (CDC).

Certain specialty and non-specialty generic medications may be covered at a higher Cost Share than other generic products. Please reference the Formulary and Schedule of Benefits for additional information. For purposes of this provision, the tier status as indicated by the Formulary will be applicable.

Off label use of FDA-approved drugs means the prescribed use of such drug which is other than that stated in its FDA-approved labeling.

Prescription Drugs must be recognized as effective for the treatment of the condition:

1. In one of the standard reference compendia;
2. In a majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or
3. By the federal secretary of the Health and Human Services.

Standard Reference Compendia means (a) The American Hospital Formulary Service Drug Information, (b) The American Medical Association Drug Evaluation, (c) The United States Pharmacopoeia-Drug Information, or (d) Other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services or the insurance commissioner.

Peer-Reviewed Medical Literature means scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

Prior Authorization and Step Therapy for Prescription Drugs

Prior Authorization is required for certain Prescription Drugs. Our Contract uses different types of restrictions to help our Members use/take Prescription Drugs in the most effective ways. For certain drugs, you or your Provider need to get Authorization from us before we will agree to cover the drug for you. This is called “Prior Authorization.” Drugs or other prescriptions not on the Formulary but determined to be Medically Necessary and appropriate by the Provider, may be submitted for Prior Authorization to our pharmacy benefits manager via fax, phone or mail with appropriate documentation to support medical necessity. Sometimes the requirement for getting Authorization in advance helps guide appropriate use of certain drugs. If you do not get this Authorization, your drug might not be covered by the Contract. Once a Prescription Drug has been Authorized for use by a Member for a specific condition, we will not later withdraw our Authorization.

After Prior Authorization has been requested and all required or applicable documentation has been submitted, we will notify you and your Provider of our decision. See the **Prior Authorization Determination and Concurrent Inpatient Review and Notification** provision under the **PRIOR AUTHORIZATION** section for our decision timeframes.

Our Contract also uses a requirement of Step Therapy for certain Prescription Drugs. We employ clinical pharmacists who review, research and analyze the efficacy and value of various drugs. Based on their reviews of clinical practice guidelines and recommended treatment of diseases, they recommend specific drugs as the first ones to try when a Member begins or requires a change in medication therapy. For most people, these medications work well. In the limited instances where one of these medications is not effective and/or appropriate for a particular Member, the prescribing Provider contacts us about Authorizing coverage for a different medication. Trying medications in this “step-by-step” fashion is called Step Therapy. This also ensures that drugs are used in the appropriate clinical order for your medical condition.

For certain drugs, we limit the amount of the drug that you can have. For example, the Contract might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per calendar day for a certain drug, we may limit coverage for your prescription to no more than one pill per calendar day.

Limited Access Drugs or Specialty Drugs

Some drugs may be limited to a Specialty Pharmacy or a specific pharmacy based upon FDA-approval. These drugs will be designated in the Formulary with such limitations.

If a Member received out-of-area emergency care and had a prescription filled, we require that the Claim be submitted for reimbursement no later than one year (365 calendar days) following the date of service. The Claim must contain an itemized statement of expenses.

There are certain medications that are required to be covered by law. These drugs are related to the treatment of cancer, diabetes and smoking cessation. Please refer to the sections of this Contract and your Schedule of Benefits regarding these covered Prescription Drugs.

Over-the-Counter (OTC) Prescriptions

We cover a variety of over-the-counter (OTC) medications when ordered by a Physician. You can find a list of covered over-the-counter medications in our Formulary – they will be marked as “OTC”. Your prescription must meet all legal requirements.

How to Fill a Prescription

Prescriptions can be filled at a Network retail pharmacy or through our mail order pharmacy.

If you decide to have your prescription filled at a Network pharmacy, you can use the Provider Directory to find a pharmacy near you. You can access the Provider Directory at guide.ambetterhealth.com on the Find a Doctor page. You can also call Member Services to help you find a pharmacy. At the pharmacy, you will need to provide the pharmacist with your prescription and your Member identification card.

Prescription Drugs filled when you are in a grace period will be subject to the **Grace Period** provision in the **PREMIUM** section of this Contract. You may be required to pay the entire cost of the medication and request reimbursement from us if you pay your premium and your coverage does not terminate. Your pharmacist’s system showing your eligibility for coverage of your Prescription Drugs following the full payment of your past due premium will be updated within two business days of receipt of your past due premium payment. If you paid the total cost of your prescription during your grace period, and your coverage is reinstated following the payment of your premium, you may request reimbursement for your prescription by submitting your Claim to us at the address shown in the **CLAIMS** section of this Contract.

Mail Order Prescription Drug Program/Prescription Drug Delivery

The mail order program is a convenient and affordable way to obtain your maintenance Prescription Drugs. A maintenance drug is one that has been established as an effective, long-term treatment for your condition. These drugs are used to treat conditions like asthma, heart disease, and high blood pressure.

Through our mail order pharmacy, you can order up to a 90 calendar day supply of your maintenance drug. Pharmacists dispense the drugs and then ship them through standard mail at no extra cost to you. Members who order a 61-90-day supply via mail order may be eligible for discounted Cost Sharing. Mail orders less than 60 calendar days are subject to the standard Cost Sharing. Refer to the Schedule of Benefits for your mail order Cost Sharing amounts. To enroll for mail order delivery or for any additional questions, please refer to our Ambetter website. Once on our website, you will find details on your Network mail order pharmacies and next steps for enrollment.

Extended Days’ Supply

Maintenance medications are generally taken daily for chronic and lifelong conditions. Extended days' supply fills (up to 90 calendar days) of select maintenance medications are available exclusively through select pharmacies. For more information, please visit our website at AmbetterHealth.com/en/WA.

Obtaining an Emergency Fill

Under certain conditions, an emergency fill of a limited amount for certain medications is a Covered Service. If your dispensing pharmacy cannot reach us regarding a Prior Authorization request because it is outside of our business hours or if we are not able to reach the prescriber for full consultation, an emergency fill may be dispensed. For a list of qualifying and excluded emergency fill medications, please visit our website at AmbetterHealth.com/en/WA.

To obtain an emergency fill, your dispensing pharmacist should contact us to submit a request. If we find the request medically appropriate, we will Authorize for you to receive either the minimum packaging size available at the time dispensed or up to a seven calendar day supply of medication. The associated Cost Share for receiving an emergency fill will be the lesser of the following:

1. Cost of the medication; or
2. The applicable pharmacy Copayment or Coinsurance for that drug, as shown on the Schedule of Benefits.

Whether subsequent fills of the same medication you received an emergency fill for is a Covered Service depends on our Prior Authorization determination. If the Prior Authorization is approved, you may obtain additional prescription fills as a Covered Service, which are subject to applicable pharmacy Cost Sharing, as shown on the Schedule of Benefits. If the Prior Authorization is not approved, additional prescription fills are non-covered under this Contract.

Self-Injectable Drugs

Self-Injectable Drugs are delivered into a muscle or under the skin with a syringe and needle. Although medical supervision or instruction may be needed in the beginning, the patient or caregiver can administer Self-Injectable Drugs safely and effectively. Self-injectable Drugs are covered under the Prescription Drug benefits; Prescription Drug Cost Share applies.

Prescription Hormone Therapy

A 12-month refill of prescription hormone therapy may be obtained at one time by the Member, unless the Member requests a smaller supply, the prescribing Provider instructs that the Member must receive a smaller supply, or the prescription hormone therapy is a controlled substance. The 12-month refill only applies to prescription hormone therapy that is able to be safely stored at room temperatures without refrigeration. If the prescription hormone therapy is a controlled substance, we will cover for the maximum refill allowed under Applicable Laws to be obtained at one time by the Member. Prior Authorization may be required.

For purposes of this provision, “prescription hormone therapy ” means any FDA-approved Prescription Drugs used to medically suppress, increase, or replace hormones that the body is not producing at intended levels and does not include glucagon-like peptide-1 and glucagon-like peptide-1 receptor agonists.

Exclusions: Prescription hormone therapy refills that are obtained in the last quarter of the calendar year if a 12-month supply of the hormone therapy drug was dispensed earlier during the calendar year are not covered.

This exclusion does not apply to new prescriptions for a different hormone therapy drug received during the last quarter of the calendar year, even if a 12-month supply of a hormone therapy drug was previously obtained.

Medication Balance-On-Hand

Medication refills are prohibited until your cumulative balance-on-hand is equal to or fewer than 15 calendar days' supply of medication. This provision operates in addition to any applicable medication quantity limit or refill guidelines.

Split-Fill Dispensing Program

You are limited to a 15 calendar day supply for the first 90 calendar days when starting new therapy using certain medications (like oral oncology). You pay half the 30 calendar day Cost Share for a 15 calendar day supply, and would be responsible for the other half of the 30calendar day Cost Share for each additional 15 calendar day supply. After 90 calendar days, you will fill your medications for 30 calendar day supplies.

Your Prescription Drug Rights

You have the right to safe and effective pharmacy services. You also have the right to know what drugs are covered by your plan and the limits that apply. If you have a question or concern about your Prescription Drug benefits, please contact us or visit AmbetterHealth.com/en/WA. If you would like to know more about your rights, or if you have concerns about your plan, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900 or www.insurance.wa.gov. If you have a concern about the pharmacists or pharmacies serving you, please contact the Washington State Department of Health at 1-360-236-4700, www.doh.wa.gov, or hsqa.csc@doh.wa.gov.

Non-Covered Services and Exclusions for Prescription Drugs:

No benefits will be paid under this benefit provision for:

1. For Prescription Drugs for the treatment of erectile dysfunction or any enhancement of sexual performance, unless such treatment listed on the Formulary.
2. For weight loss Prescription Drugs unless otherwise listed on the Formulary.
3. For immunization agents otherwise not required by the Affordable Care Act.
4. For medication that is to be taken by the Member, in whole or in part, at the place where it is dispensed.
5. For medication received while the Member is a patient at an institution that has a Facility for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a Physician's order.
7. For more than the predetermined Managed Drug Limitations assigned to certain drugs or classification of drugs.
8. For a prescription order that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the Formulary.

9. For drugs labeled "Caution - limited by federal law to Investigational use" or for Experimental and Investigational drugs.
10. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
11. For more than a 30 calendar day supply when dispensed in any one prescription or refill, or for some maintenance drugs up to a 90 calendar day supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs and other select drug categories are limited to 30 calendar day supply when dispensed by retail or mail order.
12. For Prescription Drugs for any Member who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription Drug coverage may not be reinstated at a later date.
13. Foreign Prescription Medications, except those associated with an Emergency Medical Condition while you are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States.
14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to Member's vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
15. For medications used for cosmetic purposes.
16. For infertility drugs unless otherwise listed on the Formulary.
17. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
18. For drugs or dosage amounts determined by Ambetter's Pharmacy and Therapy committee to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
19. For any drugs related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
20. For any drug dispensed from a non-lock-in pharmacy while Member is in a lock-in program.
21. For any drug related to Surrogate Pregnancy.
22. Prescription Drug contraceptive refills that are obtained in the last quarter of the calendar year if a 12-month supply of the contraceptive drug was dispensed earlier during the calendar year.
23. For any prescription or over-the-counter version of vitamin(s) unless otherwise included on the Formulary.
24. Medication refills where a Member has more than 15 calendar days' supply of medication on hand.

25. Compound drugs, unless there is at least one ingredient that is an FDA approved drug.

Prescription Drug Continuity of Coverage

If you currently have a non-preferred drug prescription refill for an antipsychotic, antidepressant, antiepileptic or other drug prescribed to treat a serious mental illness, you are medically stable on the drug, and a Network Provider continues to prescribe the drug, we may not require substitution of the non-preferred drug with a preferred drug within the same therapeutic class or increase your Cost Sharing obligation mid-plan year for the non-preferred drug. However, we may require generic substitution during the plan year if available.

For purposes of this provision, “serious mental illness” means a mental disorder that results in serious functional impairment that substantially interferes with or limits one or more major life activities as listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Drug Discount, Coupon or Copayment Card

Cost Sharing paid on your behalf for any Prescription Drugs obtained by you through the use of a Drug Discount, Coupon, or Copayment Card provided by a Prescription Drug manufacturer will apply towards your plan Deductible Amount or your Maximum Out-of-Pocket Amount for any Brand Name Drug where a generic version:

1. Is not available on the Formulary;
2. Is available on the Formulary, but you have obtained access to the Brand Name Drug through Prior Authorization, step therapy or the Prescription Drug Exception Process, as described below; or
3. Is available on the Formulary, but you need access to the Brand Name Drug through the request of a Prescription Drug Exception Process, including any Appeal of a denial of an exception request.

Prescription Drug Synchronization

Under Washington law, you have the right to request synchronization of your medications. Synchronization is alignment of your fill dates so that all of your medication-refill dates are on the same day. For example, if you fill medication A on the 5th of each month and your prescriber prescribes you a new prescription B on the 20th of the month, you have the right to request a refill for prescription B that is shorter or longer than 30 calendar days. This may help you adjust your fill dates for medication B and synchronize the fill dates with medication A. We will adjust Copayment Amounts to reflect shorter or longer coverage. If you would like to exercise this right, please call Member Services.

Non-Formulary Prescription Drugs

Under the Affordable Care Act, you have the right to request an exception for coverage of Prescription Drugs that are not listed on the plan Formulary (“non-formulary drugs”). To exercise this right, please contact your Medical Practitioner. Your Medical Practitioner can utilize the usual Prescription Drug Exception Process described below.

Prescription Drug Exception Process

A Member, a Member's Authorized Representative or a Member's prescribing Physician may request an exception to our Prescription Drug requirements, including but not limited to:

1. A substitution of a Preferred Drug, therapy or medication including specialty and no Specialty Drugs except vaccines;
2. Drug benefit limitations and procedures under our drug utilization management program such as step therapy; dosage limitations or therapeutic substitutions;
3. Access to drugs, therapies or medication that are on and off of our Prescription Drug Formulary;
4. Continuation the use of a drug if the tiering structure changes during the year, and the Member is using the drug at the time of the change.

Non urgent exception request

A Member, a Member's designee or a Member's prescribing Physician may request a standard Prescription Drug exception review. The request can be made in writing or via telephone. If we do not receive enough information to make a decision, we will notify the prescribing Physician and indicate the specific information we need to make a decision within three business day of receipt of the non-urgent exception request. When we have received sufficient information to make a decision we will provide the Member, the Member's designee or the Member's prescribing Physician with our coverage determination within three business days following the receipt of the request. Should the standard exception request be granted, we will provide coverage of the non-formulary drug for the duration of the prescription, including refills.

Urgent (Expedited) exception request

A Member, a Member's designee or a Member's prescribing Physician may request an expedited review based on exigent circumstances. Exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a non-formulary drug. If we do not receive enough information to make a decision, we will notify the prescribing Physician and indicate the specific information we need to make a decision within one business day of receipt of the urgent exception request. When we have received sufficient information to make a decision within one business day of the request being received, we will provide the Member, the Member's designee or the Member's prescribing Physician with our coverage determination. Should the expedited exception request be granted, we will provide coverage of the non-formulary drug for the duration of the exigency.

External exception request review

If we deny a request for a standard exception or for an urgent expedited exception, the Member, the Member's designee or the Member's prescribing Physician may submit an Appeal our denial under the Grievance and Appeal process as set forth in this Contract. If We do not overturn our denial of the original exception request, you may request that the subsequent denial of such request be reviewed by an Independent Review Organization (IRO). If the exception request was urgent or an emergency fill we will cover the drug while the External Review is pending. The IRO will make a determination on the External Review of an

urgent exception request and notify the Member, the Member's designee or the Member's prescribing Physician of the coverage determination no later than 72 hours following receipt of the request if the original request.

If you request External Review of an urgent (expedited) exception request, we will provide coverage of the non-formulary drug for the duration of the exigency in accordance with the IRO's determination. If the IRO reverses our denial of either an urgent or non-urgent (standard) exception request, we will retroactively cover a non-formulary drug and continue coverage for the duration of the prescription.

Lock-In Program

To help decrease overutilization and abuse, certain Members identified through our lock-in program, may be locked into a specific pharmacy for the duration of their participation in the lock-in program. Members locked into a specific pharmacy will be able to obtain their medication(s) only at specified locations. Ambetter Pharmacy, together with Medical Management will review Member profiles using specific criteria to identify patterns of overutilization and abuse and will recommend Members for participation in lock-in program. Members identified for participation in lock-in program and associated Providers will be notified of Member participation in the program via mail. Such communication will include information on duration of participation, pharmacy to which Member is locked-in, and any Appeals rights.

Coverage for Pharmacy Services

Below are frequently asked questions regarding the Pharmacy Services covered under this product:

1. Does this plan limit or exclude certain drugs my health care Provider may prescribe, or encourage substitutions for some drugs?

    - Our plan does limit certain drugs by utilizing Prior Authorization and step therapy criteria. Additionally, some drugs have quantity limits associated with them. Those quantity limits are based on the FDA maximum approved dose. Our plan does not categorically exclude any drug as this is prohibited under the Affordable Care Act (ACA), except as listed under the **NON-COVERED SERVICES AND EXCLUSIONS** under this section. Access may be granted to all non-formulary drugs through the Exception Process. The Exception Process requires documentation of ineffectiveness, contraindication or intolerance to two Formulary drugs that are commonly recognized by compendia or medical literature as treatment options for the same condition. The principal tool for selection of drugs on the Formulary is the ACA mandated benchmark count tool. Additionally, drugs are considered for inclusion on the Formulary through established Pharmaceutics and Therapeutics Committee review process.

2. When can my plan change the approved drug list (Formulary)? If a change occurs, will I have to pay more to use a drug I had been using?

    - The Formulary may change as new drugs are introduced into the market, which includes generics for certain brand drugs. The expectation set forth by the ACA and by CMS is that no negative changes, such as additions of Prior Authorization, step therapy or removal of the drug from the Formulary can take place during the benefit

year. Therefore, we make every effort to only make these changes to the Formulary once a year on January 1st. If there is a change in tiering or removal of the drug from the Formulary during a benefit year, we will provide at least 60 calendar days' notice of the change. The Member may be required to pay a higher Copayment Amount. In cases where the Member is negatively affected, the Member will be notified at least 60 calendar days in advance of the change. The Member may request an exception under the Prescription Drug Exception Process unless the drug is removed from the Formulary because it is no longer available in the market, available over-the-counter, or subject to a Black Label warning from the Food and Drug Administration.

3. What should I do if I want a change from limitations, exclusions, substitutions or cost increases for drugs specified in this plan?"
    - Prior Authorization is required for these changes. You may contact Member Services at 1-877-687-1197 to request changes to the limitations, exclusions, substitutions or cost increases for drugs covered under this plan.
4. How much do I have to pay to get a prescription filled?
    - Please review your Schedule of Benefits for costs associated with filling your prescription. The Schedule of Benefits is tailored to your specific plan and outlines Cost Sharing requirements for Generic, Brand, Non-Preferred and Specialty Drugs covered by the plan.
5. Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?
    - There is no cost differentiation for Network pharmacies. There is no coverage for prescriptions filled at non-network pharmacies.
6. How many days' supply of most medications can I get without paying another Copayment or other repeating charge?
    - Claims for a supply of less than 31 calendar days will incur one Copayment; Claims for a supply greater than 31 but less than 61 calendar days will incur two times Copayment; Claims for supply greater than and including 61 to 90 calendar days will incur three times Copayment. This schedule of Copayments applies regardless if the Claim is for exceptional supply, mail order or travel supply. Refills are allowed after Member has used up 80 percent of drug on hand. Vacation overrides are allowed for out-of-country travel only.
    - A pharmacist is authorized to provide one early refill of a prescription for Topical Ophthalmic products if the following criteria are met:
        i. The refill is requested at or after 70 percent of the predicted days of use of:
            - The date the original prescription was dispensed; or
            - The date that the last refill of the prescription was dispensed.
        ii. The prescriber indicates on the original prescription that a specific number of refills will be needed; and

iii. The refill does not exceed the number of refills that the prescriber indicated on the original prescription.

7. "What other pharmacy services does my health plan cover?"
   - No additional services are provided.

Preventive Care Benefits

Preventive care services are covered as required by the Affordable Care Act (ACA). According to the ACA, preventive care services must include the following:

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
   a. A recommendation from the ACIP of the CDC is considered in effect after the recommendation has been adopted by the director of the CDC.
   b. A recommendation is considered to be for routine use if the recommendation is listed on the immunization schedules of the CDC.
3. 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).
4. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA, to the extent the care is not illegal under Applicable Law.

Preventive Care Benefits are covered without Member Cost Share (i.e., covered in full without Deductible Amount, Copayment Amount or Coinsurance Amount) when obtained from a Network Provider or from a Non-Network Provider when Prior Authorization is approved by us when there is no Network Provider available. For current information regarding available Preventive Care Benefits, please access the federal government's website at www.healthcare.gov/center/regulations/prevention.html.

Preventive care refers to services or measures taken to promote health and early detection or prevention of diseases and injuries, rather than treating or curing them. Preventive care includes, but is not limited to, immunizations, medications, tobacco cessation treatment, examinations and screening tests tailored to an individual’s age, health and family history.

Certain services can be performed for preventive or diagnostic reasons (e.g., mammograms). If a service is deemed preventive care and is appropriately reported/billed, it will be covered under the preventive care services benefit. However, when a service is performed for diagnostic purposes and reported/billed accordingly, it will be considered a non-preventive medical benefit and appropriate Cost Share will apply. **Note:** If preventive and diagnostic services are performed during the same visit, applicable Cost Share will be taken for the latter.

Benefits for Covered Services and supplies for preventive care expense and chronic disease management benefits may include the use of reasonable medical management techniques

authorized by federal law to promote the use of high value Preventive Care Services from Network Providers. Reasonable medical management techniques may result in the application of Cost Sharing to services when a Member chooses not to use a high value service that is otherwise exempt from Deductibles, Coinsurance provisions, and Copayment Amounts, when received from a Network Provider. Such medical management techniques include but are not limited to the usage of nationally accepted criteria such as InterQual, McMillan, National Coverage Determinations, and Local Coverage Determinations in addition to Generally Accepted Standards of Medical Practice and/or recognized Standards of Care Guidelines and governing agency rules such as NCQA, URAC and the State.

As new preventive care recommendations and guidelines are issued (by the USPSTF, CDC or HRSA), those services will become covered Preventive Care Benefits. According to the ACA, coverage of new recommendations and guidelines become effective upon a plan's start or anniversary date that is one year after the date the recommendation or guideline is issued.

In addition to providing coverage in accordance with the ACA, we also provide Preventive Care Benefits in accordance with applicable State law.

Our Ambetter Health Preventive Care Guide is updated annually and contains detailed information regarding preventive care coverage available to you. It is accessible via our website at AmbetterHealth.com/en/WA. To request a paper copy, please contact Member Services for assistance.

Examples of available Preventive Care Benefits:

1. Depression screening in adults, including pregnant and post-partum Members, children and adolescents in compliance with USPSTF recommendations.
2. Prenatal vitamins and breast pumps for Members expecting the birth of a child.
3. Coverage for obesity or weight reduction or control services for children age six and over who qualify as obese, and adult patients who have a body mass index of 30 kg/meter squared or higher. Service include:
    a. Medical Nutritional Therapy (MNT) and Clinical Nutritional Therapy, including:
        i. Initial assessment and intervention;
        ii. Subsequent Individual Reassessment and Intervention; and
        iii. Group Appointments;
    b. Nutritional and Dietetic Counseling;
        i. Individual and Group;
    c. Annual, face-to-face IBT (Intensive Behavioral Therapy) for CVD (cardiovascular disease);
    d. Face-to-Face Behavioral Counseling for Obesity;
    e. Weight management classes, non-physician Provider; and
    f. Nutrition classes, non-physician Provider.
4. Coverage for cessation of Tobacco Use. Services include:
    a. Screening for Tobacco Use; and

b. For those who use Tobacco products, at least two cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:

   i. Four tobacco cessation counseling sessions of at least ten minutes each (including telephone counseling, group counseling and individual counseling) without Prior Authorization; and

   ii. All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications).

5. Preexposure prophylaxis (PrEP) HIV prevention medication and related medical support services for HIV-negative individuals at high risk of HIV acquisition are covered with no Member Cost Share, including but not limited to:

   a. Laboratory testing for HIV, sexually Transmitted Infection (STI) screening, creatinine clearance, lipid panel, hepatitis screening and Pregnancy testing;

   b. Essential medical support services such as preventive medicine counseling, preventive medicine visits and Telemedicine PrEP visits.

Maternity and Newborn Care

Covered Services and supplies include outpatient and Inpatient pre-natal and post-partum care for the following when rendered by a Network Provider:

1. Examinations, and screenings;
2. Prenatal diagnosis of genetic disorder;
3. Laboratory and radiology diagnostic testing;
4. In utero treatment for the fetus;
5. Health education;
6. Nutritional counseling;
7. Risk assessment;
8. Childbirth classes;
9. Vaginal or cesarean childbirth delivery in a Hospital or birthing center, including Facility Fees;
10. Complications of Pregnancy;
11. Termination of Pregnancy, in accordance with Applicable Laws;
12. Services of an advanced registered nurse practitioner specialist in midwifery; or
13. Other Medically Necessary services, which may be subject to Prior Authorization as outlined in this Contract in accordance with Applicable Laws.

Maternity coverage of a home birth by a midwife or nurse midwife is limited to low-risk Pregnancy.

An Inpatient stay is covered for the mother and newborn for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean delivery and does not require Prior

Authorization from a Physician or other health care Provider for the delivery. There is no limit for the mother's length of Inpatient stay, where the mother is attended by a Provider who is a Physician, certified nurse midwife, physician assistant, or advanced registered nurse practitioner. The attending Provider will determine an appropriate discharge time, in consultation with the mother. However, prior or concurrent Authorization is required when a Physician or other health care Provider prescribes a stay over 48 hours for a vaginal delivery and 96 hours for a cesarean section.

We do not require that a Physician or other health care Provider obtain Prior Authorization for the delivery. However, Prior Authorization is required for sick newborns with a complex health condition or admitted to a Neonatal Intensive Care Unit (NICU). Well baby and normal deliveries within 48 hours following a vaginal delivery or 96 hours following a cesarean delivery do not require Prior Authorization.

Follow up care after discharge including the type and location of follow-up care will be determined by the attending Provider in consultation with the mother and will include but is not limited to services provided by Attending Physicians, Home Health Agencies, and registered nurses as licensed in the state of Washington.

Other maternity benefits include parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests. Comprehensive lactation support and counseling, by a trained Provider during Pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment are covered under **Preventive Care Benefits** provision.

We may require attending Providers to obtain Prior Authorization for maternity services or care they believe to be Medically Necessary, in accordance with Applicable Laws.

Maternity care for a Member's Dependent Member and services for newborns delivered of Dependent Members are covered on the same basis as the Member.

Covered Services and supplies for a newborn will be no less than the coverage for the newborn's mother and in no event will be less than 21 calendar days even if there are separate Hospital admissions. Covered Services and supplies include: circumcision, nursery services and supplies for newborns, including newly adopted children.

Note: This provision does not amend the Contract to restrict any terms, limits or conditions that may otherwise apply to Covered Services and supplies for maternity care. This provision also does not require a Member who is eligible for coverage under a health benefit plan to:

1. Give birth in a Hospital or other health care Facility; or
2. Remain under Inpatient care in a Hospital or other health care Facility for any fixed term following the birth of a child.

Note: This provision does not amend the Contract to restrict any terms, limits, or conditions that may otherwise apply to Surrogates and children born from Surrogates. Please reference **GENERAL NON-COVERED SERVICES AND EXCLUSIONS** section as limitations may exist.

Duty to Cooperate

We do not cover services or supplies related to a Member's Pregnancy for when a Member is acting as a Surrogate during the course of their Surrogacy Arrangement. For more information

on excluded services, please see the **GENERAL NON-COVERED SERVICES AND EXCLUSIONS** section. Members who are a Surrogate at the time of enrollment or Members who agree to a Surrogacy Arrangement during the plan year must, within 30 calendar days of enrollment or agreement to participate in a Surrogacy Arrangement, send us written notice of the Surrogacy Arrangement to Ambetter from Coordinated Care, Attn: Member Services, 1145 Broadway, Suite 700 Tacoma, WA 98402. In the event that a Member fails to comply with this provision, we reserve our right to enforce this Contract on the basis of fraud, misrepresentation or false information, up to and including recoupment of all benefits that we paid on behalf of the Surrogate during the time that the Surrogate was insured under our Contract, plus interest, attorneys' fees, costs and all other remedies available to us.

Benefits for the termination of a Pregnancy obtained from a Network Provider and/or a Non-Network Provider are covered without Member Cost Share. Services provided by Non-Network Providers are subject to Prior Authorization.

Newborns' and Mothers' Health Protection Act Statement of Rights

If expenses for Network Hospital confinement in connection with childbirth are otherwise included as Covered Services and supplies, we will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health plan issuers generally may not restrict benefits provided for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, we will provide benefits for Covered Services and supplies incurred for a shorter stay if the attending Provider (e.g., your Physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

The level of benefits and out-of-pocket costs for any later part of the 48-hour stay for a vaginal delivery or 96-hour for cesarean section will not be less favorable to the mother or newborn than any earlier part of the stay. We do not require that a Physician or other health care Provider obtain Authorization for prescribing a length of stay of up to 48 hours following a vaginal delivery or 96 hours following a cesarean section. However, Prior Authorization is required when a Physician or other health care Provider prescribes a stay over 48 hours for a vaginal delivery and 96 hours for a cesarean section.

We do not require that a Physician or other health care Provider obtain Prior Authorization for the delivery. However, Prior Authorization is required for sick newborns with a complex health condition or admitted to a Neonatal Intensive Care Unit (NICU). Well baby and normal deliveries within 48 hours following a vaginal delivery or 96 hours following a cesarean delivery do not require Prior Authorization.

Note: This provision does not amend the Contract to restrict any terms, limits, or conditions that may otherwise apply to Covered Services and supplies for childbirth.

Prostate Cancer Screening

When Medically Necessary, Covered Services include an annual digital rectal examination and prostate specific antigen test performed to determine the level of prostate specific antigen in

the blood. Coverage is available to all Members, regardless of age, when these services are rendered by a Medical Practitioner.

Radiology, Imaging and Other Diagnostic Testing

Medically Necessary radiology services, imaging and tests performed for diagnostic reasons are Covered Services (e.g., X-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Tomography (PET/SPECT), mammogram, ultrasound). Prior Authorization may be required, see your Schedule of Benefits for details. **Note:** Depending on the service performed, two bills may be incurred - both subject to any applicable Cost Sharing - one for the technical component (the procedure itself) and another for the professional component (the reading/interpretation of the results by a Physician or other qualified practitioner).

Non-Network Providers should not bill you for Covered Services for any amount greater than your applicable Cost Sharing responsibilities when Balance Billing Protections apply to the radiology, imaging and other diagnostic testing services.

Routine Foot Care

Routine foot care services are covered when Medically Necessary. If Medically Necessary the Contract will cover orthopedic shoes, arch supports, foot orthotics, shoe lifts, wedges and the treatment of corn and calluses, trimming of nails and foot care appliances for preventive care.

Sleep Studies

Sleep studies are covered when determined to be Medically Necessary; Prior Authorization may be required. **Note:** A sleep study can be performed either at home or in a Facility.

Transplant Benefits

Covered Services for transplant service expenses: Transplants are a Covered Service when a Member is accepted as a transplant candidate and pre-authorized in accordance with this Contract. Prior Authorization must be obtained through the Center of Excellence, a Network facility or in a non-network facility when Prior Authorization is approved by us when there is no Network adequacy, before an evaluation for a transplant. We may require additional information such as testing and/or treatment before determining medical necessity for the transplant benefit. Authorization must be obtained prior to performing any related services to the transplant Surgery. Transplant services must meet medical criteria as set by Medical Management policy. Coverage related to transplant services is available to both the recipient and donor of a covered transplant as follows:

1. If both the donor and recipient have coverage provided by us each will have their benefits paid by their own coverage program.
2. If you are the recipient of the transplant, the benefits under this Contract will be provided for both you and the donor. In this case, payments made for the donor will be charged against Members benefits.

3. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Contract will be provided for you. However, no benefits will be provided for the recipient.
4. If lapse in coverage is due to non-payment of premium, then no services related to transplants will be paid as a Covered Service.

Once medical compatibility has been determined that a Member and donor are an appropriate candidate for a Medically Necessary transplant, or live donation, Covered Services will be provided for both the transplant recipient and the donor:

1. Pre-transplant evaluation services including medical consultations, office visits, laboratory, and di-agnostic testing.
2. Pre-transplant collection or harvesting of the organ from the donor.
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
4. Including outpatient Covered Services related to the transplant Surgery, pre-transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressive drug therapy, etc.
5. Pre-transplant stabilization, meaning an Inpatient stay for Medically Necessary stabilization to prepare for a later transplant, whether or not the transplant occurs.
6. The transplant itself, including the acquisition cost for the human organ, artificial organ or bone marrow when authorized through the Center of Excellence and services are performed at a Network Facility.
7. Post-transplant follow-up visits and treatments including medical consultations, office visits, laboratory, and diagnostic testing.
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.
9. All ancillary costs incurred and medical expenses by the donor; shall be paid under the transplant recipient policy, this includes travel, lodging, food and mileage.

Please refer to the Member Transplant Travel Reimbursement Policy for outlined details on reimbursement limitations at AmbetterHealth.com/en/WA.

These medical expenses for the donor are Covered Services under the Member's Contract, after benefits for the Member's s own expenses have been paid. In the event of such coverage, the otherwise existing coverage of a live donor shall be secondary to benefits under the Member's Contract.

Ancillary Center of Excellence and our Service Benefits:

A Member may obtain services in connection with an authorized transplant from any Physician. However, if a transplant is performed in a Center of Excellence, a Network Facility, or in our approved non-network Facility when there is no Network adequacy:

1. We will pay for the following services when the Member is required to travel more than 60 miles from their Residence to the Center of Excellence, a Network Facility, or in our approved non-network Facility when there is no Network adequacy:

2. We will pay for the following services, subject to the maximum identified in the Schedule of Benefits:
    a. Transportation for the Member, any live donor and a companion/family member(s) to accompany both the Member and the donor to and from the Center of Excellence, a Network Facility, or in our approved non-network Facility when there is no Network adequacy in the United States.
    b. When the Member, donor and/or companion(s) is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to the total miles traveled by the transplant recipient and by the donor and their respective companion(s), to and from their respective homes to the transplant facility, plus miles traveled:
        i. Between the transplant facility and local lodging; and
        ii. Between a transit hub (e.g., airport, train station, bus station) and either the transplant facility or local lodging.
    d. Lodging at or near the Center of Excellence, a Network Facility, or in our approved non-network Facility when there is no Network adequacy for any live donor and companion/family member(s) accompanying the Member and the donor while the Member and the donor are confined in the Center of Excellence, a Network Facility, or in our approved non-network Facility when there is no Network adequacy in the United States. We will reimburse Members for the proof of costs directly related for transportation, lodging and any of the approved items listed in the Member transplant reimbursement guidelines. However, you must make the arrangements and provide the necessary paid receipts for reimbursement within six months of the date of service in order to be reimbursed.

Please refer to the member resources page for Member reimbursement transplant travel forms and information at AmbetterHealth.com/en/WA.

Non-Covered Services and Exclusions:

In addition to any other exclusions and limitations described in this Contract, there are no benefits provided or paid under these Transplant Service Expense Benefits for the following:

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of a human organ or tissue, not obtained through the Center of Excellence, a Network Facility, or in our approved non-network Facility when there is no Network adequacy.
4. To keep a donor alive for the transplant operation, except when authorized through the Center of Excellence, a Network Facility, or in our approved non-network Facility when there is no Network adequacy.
5. For a live donor to receive an organ transplant to replace the donated organ.

6. Related to transplants unauthorized though the Center of Excellence, a Network Facility, or in our ap-proved non-network Facility when there is no Network adequacy and is not included under this pro-vision as a transplant.
7. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the FDA regulation, regardless of whether the trial is subject to FDA oversight.
8. The acquisition cost for the organ or bone marrow, when provided at an unauthorized Facility or not obtained through the Center of Excellence, a Network Facility, or in our approved non-network Facility when there is no Network adequacy.
9. For any transplant services and/or travel related expenses for the Member and donor, when preformed outside of the United States.
10. The following ancillary items listed below, will not be subject to Member reimbursement under this Contract:
    a. Alcohol/tobacco
    b. Car, trailer or truck rental (unless pre-approved by Case Management)
    c. Vehicle maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
    d. Parking (unless preapproved by Case Management).
    e. Storage rental units
    f. Temporary housing incurring rent/mortgage payments.
    g. Loss of wages due to time off from work required for transplant for recipient, donor, or companion(s).
    h. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
    i. Moving violations tickets or parking tickets.
    j. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
    k. Any services related to pet care, boarding, lodging, food, and/or travel expenses.
    l. Expenses for persons other than the transplant recipient, donor or their respective companion(s).
    m. Expenses for lodging when the transplant recipient, donor or their respective companion(s) is staying with a relative, friend or otherwise have free lodging.
    n. Any expense not supported by a receipt
    o. Upgrades to first class travel (air, bus, and train)
    p. Personal care items (e.g., shampoo, deodorant, clothes)
    q. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA precheck, and early check-in boarding fees, extra baggage fees.

r. Souvenirs (e.g., t-shirts, sweatshirts, toys)

s. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type

t. Any fuel costs/charging station fees for any vehicle, not related to travel to and from the Center of Excellence or our approved Facility when there is no Network adequacy. (**Note:** Mileage is reimbursable.)

u. Any tips, concierge, club level floors, and gratuities.

v. Salon, barber, and spa services.

w. Insurance premiums.

x. Cost Share amounts owed to the transplant surgeon or facility or other Provider.

Urgent Care

Urgent Care services is care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not severe enough to require emergency room care. Urgent Care services include Medically Necessary services by Network Providers and services provided at an Urgent Care Center including Facility costs and supplies. Care that is needed after a Primary Care Provider's normal business hours is also considered to be Urgent Care. Your Preventive Care Benefits may not be used at an Urgent Care Center.

Members are encouraged to contact their Primary Care Provider for an appointment before seeking care from another Provider, but contracted Urgent Care Centers and walk in clinics can be used when an urgent appointment is not available. If the Primary Care Provider is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-877-687-1197. The 24/7 Nurse Advice Line is available 24 hours a day, seven days a week. A registered nurse can help you decide which care most appropriate for your specific need. If you believe you are experiencing an Emergency Medical Condition, please call 911 or go to the nearest emergency room. For a Behavioral Health crisis, call or text 988.

Wellness Programs and Other Offerings

In connection with this Contract, we may offer wellness programs and other services to Members that serve to remove barriers to accessing health services and improve overall health outcomes. These programs and services are available when your coverage begins and continue as long as your coverage remains active. Participation in these programs and services is optional and available at no additional cost to Members. The programs and services are available to you as part of this Contract. We may make changes to the terms and conditions of the programs and services or discontinue them at any time. Program tools and service may vary within your market. To inquire about these programs and other offerings, and to learn about what programs are available in your area, please visit our website at AmbetterHealth.com/en/WA or by contacting Member Services.

The Ambetter Health preventive care and wellness program includes offerings for health check-ups, screenings for common conditions and vaccinations. Rewards, including those that may be converted to monetary value, may be available through the "My Health Pays" program for completing specific activities that promote healthy behaviors and address Social Determinants of Health. Members may receive communications and outreach about this

program. Ambetter reserves the right to apply any such rewards to any unpaid premiums or related amounts you may owe.

We also offer general wellness, health improvement and Care Management programs that may include a reward or incentive that you may earn for completing different wellness-related activities.

If you have a medical condition that may prohibit you from participating in a wellness program, we may require you to provide verification, such as an affirming statement from your Physician, that your medical condition makes it unreasonably difficult or inadvisable to participate in the wellness or health improvement program, in order for you to receive the reward or incentive.

You can access other services in connection with this Contract, such as the “Ambetter Perks” program, which offers discounts on a wide range of activities, services, goods, financial tools, memberships, out-of-pocket prescription expenses, over-the-counter (OTC) health products, and health and wellness-related services addressing Social Determinants of Health and healthy lifestyle. Members are responsible for paying for the discounted goods or services and we do not endorse any vendor, goods or services associated with the program. Members may also have access to a zero-interest line of credit through the Ambetter Perks program for paying their Deductible Amounts, Copayment Amounts, and Coinsurance Amounts on Covered Services, with several repayment options to fit their needs. The Ambetter Perks program is offered to all Members. We are not involved in administering programs; you will communicate directly with any vendors if you choose to participate.

PRIOR AUTHORIZATION

Prior Authorization Required

Some medical and Behavioral Health Covered Services require Prior Authorization. In general, when your Primary Care Provider or other Network Provider recommends care that needs Prior Authorization, it is up to the Network Provider to obtain Authorization from us prior to providing a service or supply to a Member. Network Providers cannot bill you for services for which they fail to obtain Prior Authorization as required. However, there are some Network Eligible Services for which you, the Member, must obtain the Prior Authorization.

For services or supplies that require Prior Authorization, as shown on the Schedule of Benefits, you must obtain Authorization from us before you or your Dependent Member:

1. Receives a service or supply from a Non-Network Provider (See the "**Services from Non-Network Providers**" provision in this section for further details);
2. Are admitted into a Network Facility by a Non-Network Provider; or
3. Receive a service or supply from a Network Provider to which you or your Dependent Member were referred by a Non-Network Provider.

You do not need to obtain Prior Authorization from us or from any other person (including your PCP) in order to obtain access to obstetrical or gynecological care from a Medical Practitioner in our Network who specializes in obstetrics or gynecology. The Medical Practitioner, however, may be required to comply with certain procedures in accordance with Applicable Laws, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating Medical Practitioners who specialize in obstetrics or gynecology, please refer to the Provider Directory. (See the **Provider Directory** provision in the **IMPORTANT INFORMATION** section.) If you need assistance with finding a provider, please contact Member Services.

Pursuant to the federal No Surprises Act and Washington State Balance Billing Protection Act, Emergency Services received from a Non-Network Provider are Covered Services without Prior Authorization.

Prior Authorization Requests

Prior Authorization (medical and Behavioral Health) requests must be received by phone/e-fax/Provider portal as follows:

1. At least five calendar days prior to an elective non-urgent admission as an Inpatient in a Hospital, Extended Care or Rehabilitation Facility, or Hospice Facility.
2. At least 30 calendar days prior to the initial evaluation for organ transplant services.
3. At least 30 calendar days prior to receiving clinical trial services.
4. At least five calendar days prior to the start of Home Health Care, except those Members needing Home Health Care after Hospital discharge when possible.
5. Inpatient or residential Substance Use Disorder treatment does not require Prior Authorization to begin but will be subject to Utilization Review after two business days

following admission excluding weekends and holidays following admission to a Behavioral Health agency.

6. Inpatient or residential Substance Use withdrawal services does not require Prior Authorization to begin but will be subject to Utilization Review after three business days.

Inpatient Admissions to treat a covered Emergency Medical Condition do not require Prior Authorization but will be subject to Utilization Review after notification. All Inpatient admissions, (emergent and non-emergent) require notification within one business day from the date of Inpatient Admission.

Prior Authorization Determination and Concurrent Inpatient Review and Notification

After Prior Authorization has been requested and all required or applicable documentation has been submitted, we will notify you and your Provider of our decision as required by Applicable Law:

1. For urgent concurrent reviews received at least 24 hours prior to the expiration of a previously approved course of treatment, within 24 hours or receipt of the request. For all other concurrent requests, if the request is submitted electronically, within one calendar day, and if the request was not submitted electronically, within two calendar days.
2. For expedited pre-service requests:
    a. within two calendar days if the request was submitted through a non-electronic Prior Authorization process. If additional information is needed to make a decision, we will request the additional information from the Provider or Facility within one calendar day from the date of submission of the non-electronic Prior Authorization request; or
    b. within one calendar day if the request was submitted through an electronic Prior Authorization process. If additional information is needed to make a decision, we will request the additional information from the Provider or Facility within one calendar day from the date of submission of the electronic Prior Authorization request.
3. For standard non-urgent pre-service requests:
    a. within five calendar days if the request was submitted through a non-electronic Prior Authorization process. If additional information is needed to make a decision, we will request the additional information from the Provider or Facility within five calendar days from the date of submission of the non-electronic Prior Authorization request; or
    b. within three calendar days (excluding holidays) if the request was submitted through an electronic Prior Authorization process. If additional information is needed to make a decision, we will request the additional information from the Provider or Facility within one calendar day from the date of submission of the electronic Prior Authorization request.

4. For post-service review requests, within 30 calendar days of receipt of the request.

Prior Authorization may be required for certain Prescription Drugs. See the **Prior Authorization and Step Therapy for Prescription Drugs** provision under the **Prescription Drug Benefits** provision in the **COVERED SERVICES** section for more details, including procedures for requesting an exception to our requirements.

In situations where additional information is needed to make a determination, these timeframes may be extended in accordance with Applicable Law.

How to Obtain Prior Authorization

To obtain Prior Authorization or to confirm that a Network Provider has obtained Prior Authorization, contact us by telephone before the service or supply is provided to the Member. You can also view your Authorization status using your secure Online Member Account. To register, go to AmbetterHealth.com/en/WA.

Prior Authorization by us entitles a Member to receive Covered Services from a specified health care Provider. Covered Services shall not exceed the limits of the approved Authorization and are subject to eligibility and all other terms, conditions, limitations and exclusions of this Contract. Prior Authorization approvals will not expire sooner than 45 calendar days from the date of our determination. Members who have a complex or serious medical or psychiatric condition may receive a standing Authorization for specialist services.

Emergency Services

In cases of Emergency Services received due to an Emergency Medical Condition, benefits will not be reduced for failure to comply with Prior Authorization requirements. However, if you are admitted to the Hospital for treatment to Stabilize your Emergency Medical Condition, we must be contacted within one business day of your admission or as soon as reasonably possible after the admission. If we require Prior Authorization or concurrent review for post-evaluation or Post-Stabilization Services, we will provide access to an Authorized Representative 24 hours a day, seven days a week, to facilitate review.

In the event we do Authorize coverage of Emergency Services, we will not subsequently retract our Authorization after the Emergency Services have been provided or reduce payment for an item or service furnished in reliance on Prior Authorization, unless the Authorization was based on a material misrepresentation about the Member's health condition made by the Provider of Emergency Services.

Coverage of Emergency Services is subject to any applicable Cost Sharing.

Services from Non-Network Providers

Except when Balance Billing Protections apply to a Covered Service provided by a Non-Network Provider, we do not normally cover services received from Non-Network Providers. If a situation arises where a Covered Service cannot be obtained from a Network Provider located within a reasonable amount of time and distance established by us, we may provide Prior Authorization for you to obtain services from a Non-Network Provider at no greater cost to you than if you went to a Network Provider. If Covered Services are not available from a

Network Provider, you or your PCP must request Prior Authorization from us before you may receive services from a Non-Network Provider. Otherwise, you will be responsible for all charges incurred.

Except as required by the Balanced Bill Protection Act and the No Surprises Act for services provided at a non-network Hospital or Surgical Center, when a non-emergency Covered Service is received from a Non-Network Provider as Authorized by us, and there were a sufficient number and type of Network Providers available to provide that particular Covered Service, the Allowed Amount is either:

1. the amount negotiated, if any, that has been mutually agreed upon by us and the Provider as payment in full. When the Allowed Amount is negotiated, the Provider may not Balance Bill you for the difference between what the Provider charges and amount negotiated; or
2. the amount that would be paid under Medicare. When the Allowed Amount is set by Medicare, the Provider may Balance Bill you for the difference between what the Provider charges and amount set by Medicare.

If there are an insufficient number of Network Providers or Provider-types in your area necessary to provide a particular Covered Service, we will ensure that you can obtain the Covered Service from a Provider or Facility within a reasonable proximity, regardless of whether the service is the result of an Emergency Medical Condition. You must request Prior Authorization from us prior to receiving non-emergency services from a Non-Network Provider or non-network Facility. In any such case, the Allowed Amount will be the lesser of:

1. the amount negotiated, if any, that has been mutually agreed upon by us and the Non-Network Provider as payment in full, or
2. the amount reasonably accepted by the Non-Network Provider (not to exceed the Provider’s Billed Amount).

Regardless of the Allowed Amount, you will be able to receive the Covered Service at no greater cost than if the service were obtained from a Network Provider.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

This Contract only covers certain Medically Necessary Covered Services. If you are uncertain about whether a service or material is covered please contact Member Services before the service or material is provided.

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the Member in the absence of insurance covering the charge.
2. Expenses, fees, taxes or surcharges imposed on the Member by a Provider (including a Hospital) but that are actually the responsibility of the Provider to pay.
3. Any services performed for a Member by a Member's Immediate Family.
4. Any services not identified and included as Covered Services under the Contract. You will be fully responsible for payment for any services that are not Covered Services.
5. For any non-Medically Necessary court ordered care for a medical/Surgical or mental health/Substance Use Disorder diagnosis, unless required by state law.

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

1. Administered or ordered by a Physician or Medical Practitioner; and
2. Medically Necessary to the diagnosis or treatment of an injury or illness, or covered under the **Preventive Care Benefits** provision.

Excluded services are:

1. For services or supplies that are provided prior to the Effective Date or after the termination date of this Contract.
2. For any portion of the charges that are in excess of the Eligible Expense.
3. Any services or materials for non-emergency or non-urgent care received outside the United States.
4. Any service or material that requires Prior Authorization under this Contract by the Member, not the Network Provider, and where no Prior Authorization has been obtained by the Member.
5. Routine foot care, unless Medically Necessary.
6. Services or supplies for which no charge is made, or for which a charge would not have been made if the Member had no health care coverage or for which the Member is not liable.
7. Services or supplies for weight modification, including but not limited to Surgical treatment of obesity, wiring of the teeth, all forms of intestinal bypass Surgery and bariatric Surgery, except as specifically covered in the **COVERED SERVICES** section of this Contract.

8. For weight loss programs, gym memberships, exercise equipment or meal preparation programs.
9. For cosmetic breast reduction or augmentation, except for the Medically Necessary treatment of Gender Dysphoria.
10. For services and supplies rendered for infertility treatment, except as expressly provided for in this Contract.
11. For the reversal of sterilization.
12. For expenses for television, telephone, or expenses for other persons.
13. For telephone consultations between Providers, except those meeting the definition of Telemedicine or Virtual 24/7 Care benefits.
14. For failure to keep a scheduled appointment.
15. For Dental Services, including orthodontia, braces for any medical or dental condition, Surgery and treatment for oral Surgery, except as expressly provided for under the **COVERED SERVICES** provision.
16. For Cosmetic Treatment, including when it is incidental to or follows Surgery or an injury that was covered under the Contract, with the exception of Reconstructive Surgery, Medically Necessary treatment of Gender Dysphoria or services performed to correct a congenital anomaly or birth defect.
17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the **Transplant Benefits** provision.
18. For eye refractive Surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
19. For vocational therapy, recreational therapy, and vocational Rehabilitation.
20. For Experimental or Investigational treatment(s) services. The fact that an Experimental or Investigational treatment is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an Experimental or Investigational treatment of that particular condition. Any service excluded based on Experimental or Investigational status will be done so in writing within 20 calendar days of receipt of a fully documented request. We may extend the review period beyond 20 calendar days only with the informed written consent of the Member.
21. As a result of an injury or illness arising out of, or in the course of, employment for wage or profit, if the Member is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a Member's right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a Member's workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
22. Surrogacy Arrangement. Health care services, including supplies and medication, to a Surrogate, including a Member acting as a Surrogate or utilizing the services of a Surrogate who may or may not be a Member, and any child birthed by a Surrogate

Member as a result of a Surrogacy Arrangement. This exclusion applies to all health care services, supplies and medication to a Surrogate including, but not limited to:

a. Prenatal care;
b. Intrapartum care (or care provided during delivery and childbirth);
c. Postpartum care (or care for the Surrogate following childbirth);
d. Mental Health Disorder services related to the Surrogacy Arrangement;
e. Expenses relating to donor semen, including collection and preparation for implantation;
f. Donor gamete or embryos or storage of same relating to a Surrogacy Arrangement;
g. Use of frozen gamete or embryos to achieve future conception in a Surrogacy Arrangement;
h. Preimplantation genetic diagnosis relating to a Surrogacy Arrangement;
i. Any complications of the child or Surrogate resulting from the Pregnancy; or
j. Any other health care services, supplies and medication relating to a Surrogacy Arrangement.

Any and all health care services, supplies or medication provided to any child birthed by a Surrogate as a result of a Surrogacy Arrangement are also excluded, except where the child is the adoptive child of Members possessing an active Contract with us and/or the child possesses an active Contract with us at the time of birth.

23. For fetal reduction Surgery, unless Medically Necessary.
24. For the following miscellaneous items: care or complications resulting from non-covered services; domiciliary care; home test kits, unless required by Applicable Law; care or services provided to a non-member biological parent; nutrition or dietary supplements, when not Medically Necessary; pre-marital lab work; processing fees; Rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the Service Area; treatment of spider veins; non-emergency transportation expenses, unless specifically described in this Contract.
25. Custodial Care unless provided as part of a Physician approved treatment plan under the **Home Health Care Service Benefits** or **Hospice Care Service Benefits provisions.**
26. Orthognathic Surgery and supplies unless due to Temporomandibular Joint (TMJ) disorder or injury, sleep apnea or congenital anomaly.
27. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
28. For mental health examinations and services involving:
    a. School funded/administered services for psychological testing associated with the evaluation and diagnosis of learning disabilities;

b. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a Network Provider determines such evaluation to be Medically Necessary;

c. Testing of aptitude, ability, intelligence or interest;

d. Services which are custodial in nature.

29. Habilitative Services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

30. For any medical or recreational use of cannabis or marijuana.

31. Immunizations that are not Medically Necessary or medically indicated. This includes those used for travel and occupational.

32. Naprapathic expenses, services, and treatments for conditions caused by contracted, injured, spasmed, bruised, and/or otherwise affected myofascial or connective tissue.

33. For expenses, services and treatments of prevention, self-healing and use of natural therapies.

34. For expenses, services, and treatments related to private duty nursing in an Inpatient, Outpatient and home location.

35. For expenses for services related to dry needling.

36. Vehicle installations or modifications which may include, but are not limited to: adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.

37. For Assertive Community Treatment (ACT).

TERMINATION

Termination of Contract

All coverage will cease on termination of this Contract. This Contract will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the **Grace Period** provision in this Contract.
2. The date of termination provided to us by the Exchange or by the entity through which you enrolled upon your request of cancelation.
3. The date we decline to renew this Contract, as stated in the **Discontinuance** provision of this Contract.
4. The date of your death.
5. The date a Member's eligibility for coverage under this Contract ceases as determined by the Exchange or by the entity through which you enrolled.
6. For a covered Eligible Child reaching the limiting age of 26, coverage under this Contract, for an Eligible Child, will terminate at 11:59 p.m. PST on the last calendar day of the year in which the Eligible Child reaches the limiting age of 26.

Paid premiums that are not earned due to Contract termination will be refunded.

An enrolled Dependent Member who would cease to be a qualified family member by reason of termination of marriage or your death may choose to continue under the Contract. An enrolled Dependent Member will replace you as the Primary Member and a proper adjustment will be made in the premium required for this Contract to continue. Premiums paid and not earned due to your death will be refunded.

Refund upon Termination

We will refund any premium paid for months after Contract termination is effective. You may terminate this Contract at any time by notifying Washington Health Benefit Exchange or the entity through which you enrolled. Termination is effective the last calendar day of the month in which notice is provided. Upon cancellation or termination, we will promptly return any excess premium paid, back to the original method of payment and/or payor, but in any event will process the refund within 20 calendar days. If we do not refund payments within 30 calendar days of timely receipt of your notice, we will pay a penalty of 10 percent of any excess premium paid.

Discontinuance

90 Day Notice: If we discontinue offering all Contracts issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 calendar days prior to the date that we discontinue coverage. You will be offered an option to purchase any other coverage in the individual market we offer in your

state at the time of discontinuance of this Contract. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180 Day Notice: If we discontinue offering all individual Contracts in the individual market in the state where you reside, we will provide a written notice to you and the Commissioner of Insurance at least 180 calendar days prior to the date that we stop offering and terminate all existing individual Contracts in the individual market in the state where you reside.

Notification Requirements

It is the responsibility of you or your former lawful Spouse or state registered domestic partner to notify us within 31 calendar days of your legal divorce.

REIMBURSEMENT AND SUBROGATION

As used herein, the term “third-party” means any party that is, or may be, or is claimed to be responsible for illness or injuries to a Member. Such injuries or illness are referred to as “third-party injuries.” Third-party includes any parties, persons, entities, or insurers actually, possibly or potentially responsible for payment of expenses associated with the care or treatment of third-party injuries.

If this plan provides benefits under this Contract to a Member for expenses incurred due to third-party injuries, then the plan retains the right to repayment of the full cost of all benefits provided by this plan on behalf of the Member that are associated with the third-party injuries to the extent permitted by Applicable Law. The plan’s subrogation and reimbursement rights of recovery apply to any and all sources of recovery, including but not limited to:

1. Payments made by a third-party or any insurance company on behalf of the third-party;
2. Any payments or awards under an uninsured or underinsured motorist coverage policy;
3. Any workers’ compensation or disability award or settlement;
4. Medical payments coverage under any automobile policy, premises or homeowners medical payment coverage or premises or homeowners insurance coverage; and
5. Any other payments from a source intended to compensate a Member for third-party injuries.

By accepting benefits under this plan, the Member specifically acknowledges the plan’s right of subrogation. When this plan provides health care benefits for expenses incurred due to third-party injuries, the plan shall be subrogated to the Member’s rights of recovery against any party to the extent of the full cost of all benefits provided by this plan to the extent permitted by Applicable Law. The plan may proceed against any party with or without the Member’s consent.

By accepting benefits under this plan, the Member also specifically acknowledges the plan’s right of reimbursement. This right of reimbursement attaches when this plan has provided health care benefits for expenses incurred due to third-party injuries and the Member or the Member’s representative has recovered any amounts from any source. By providing any benefit under this plan, the plan is granted an assignment of the proceeds of any settlement, judgment or other payment received by or on behalf of the Member to the extent of the full cost of all benefits provided by this plan and to the extent permitted by Applicable Law. The plan’s right of reimbursement is cumulative with and not exclusive of the plan’s subrogation right and the plan may choose to exercise either or both rights of recovery.

By accepting benefits under this plan, the Member agrees to assign to the plan any claims or rights of recovery the Member has against any third-party or under any automobile policy or other coverage, to the full extent of the health care benefits for expenses incurred due to third-party injuries that this plan provides. This assignment allows the plan to pursue any claim or right of recovery the Member may have, whether or not the Member chooses to pursue the claim.

To the extent required by Applicable Law, this plan will not recover by subrogation or reimbursement until the Member has been fully compensated for the Member’s loss.

As a condition for our payment, the Member or anyone acting on the Member's behalf (including, but not limited to, the guardian, legal representatives, estate, or heirs) agrees:

1. To promptly provide to us information about the loss and its cause, including, but not limited to, supplying us with information about any potentially liable third parties, defendants, and/or insurers related to the Member's claim or rights of recovery.
2. To promptly inform us in writing within 30 calendar days of any notice given by or on behalf of the Member to any party of the intention to make a Claim or file a lawsuit to recover damages or obtain compensation in connection with third-party injuries sustained by the Member.
3. To include the amount of benefits paid by us on behalf of a Member in any Claim made against any third-party.
4. That we:
    a. Will have a lien on any settlement, judgment, or other source of compensation received by a Member in connection with the loss equal to the benefit amount we have provided or paid.
    b. May give notice of that lien to any third-party or third-party's agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect our rights.
    d. Are subrogated to all of the rights of the Member against any third-party to the extent of the benefits paid on the Member's behalf.
    e. May assert that subrogation right independently of the Member.
5. To fully cooperate with us and do whatever is necessary to secure our rights of subrogation and reimbursement under this Contract. In addition, you agree to take no action that prejudices our reimbursement and subrogation rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan to the extent permitted by Applicable Law.
6. To sign, date, and deliver to us any documents we request that protect our reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a third-party without providing us with written notice no less than 30 calendar days prior to the settlement.
8. To reimburse us from any money received from any third-party, to the extent of benefits we paid for the illness or injury, to the extent permitted by Applicable Law, whether obtained by settlement, judgment, or otherwise, and whether or not the third-party's payment is expressly designated as a payment for medical expenses.
9. That we may reduce other benefits under the Contract by the amounts a Member or anyone acting on the Member's behalf has agreed to reimburse us.
10. In the event that a Member and/or a Member's agent or attorney fails to comply with any of the above conditions, the Member shall be responsible for directly reimbursing us for the full amount of any benefits we have provided, and we may recover the full amount of

any benefits we have provided for any third-party injury through legal action against the Member and/or Member's agent or attorney.

Our subrogation and reimbursement rights shall be limited to the excess of the amount required to fully compensate the Member for the loss sustained, by the Member, to the extent required by Applicable Law.

Subject to the above provisions, if the Member is entitled to or does receive money from any source as a result of the events causing the injury or illness, including but not limited to any liability insurance or uninsured/underinsured motorist funds, our Contract benefits are secondary, not primary.

To the extent that the Member recovers funds from any source that may serve to compensate for medical injuries or medical expenses, the Member agrees to hold such monies in trust or in a separate identifiable account until our subrogation and reimbursement rights are fully determined. We have an equitable lien over such monies to the full extent of our Contract payments and/or the Member agrees to serve as constructive trustee over the monies to the extent of our Contract payments.

If reasonable attorney's fees and costs have been incurred by an attorney for the Member in connection with obtaining recovery, under certain conditions, we will reduce the amount of reimbursement to us by the amount of an equitable apportionment of such attorney's fees and costs between the Member and us. This reduction will be made only if each of the following conditions have been met:

1. we receive a list of the fees and associated costs before settlement and
2. the Member's attorney's actions were reasonable and necessary to secure recovery.

Implementation of this section shall be a part of Claims administration under the Contract and we shall therefore have discretion to interpret its terms.

COORDINATION OF BENEFITS

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

The order of benefit determination rules govern the order which each Plan will pay a Claim for benefits.

The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its Contract terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable Expense.

Definitions

For the purpose of this Section, the following definitions shall apply:

A **Plan,** as used in this section, is any of the following that provides benefits or services for medical care or treatment or treatment. A plan includes group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under the above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan. “This Plan” means, in this COB provision, the part of the Contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when you have health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the Claim equal 100 percent of the total Allowable Expense for that

Claim. This means that when this Plan is secondary, it must pay the amount that which, when combined with what the Primary Plan paid, totals 100 percent of the highest Allowable Expense. In addition, if this Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for you. This reserve must be used to pay any expenses during that calendar year, whether or not they are an Allowable Expense under this Plan. If this Plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

Allowable Expense except as outlined below is a health care expense, including Deductibles, Coinsurance and Copayments, and without reduction for any applicable Deductible, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. When coordinating benefits, any Secondary Plans must pay an amount which, together with the payment made by the Primary Plan, cannot be less than the same allowable expense as the Secondary Plan would have paid if it was the Primary Plan. In no event will a Secondary Plan be required to pay an amount in excess of its maximum benefit plus accrued savings.

1. If you advise us that all plans covering you are high-deductible health plans and you intend to contribute to a health savings account established according to Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's Deductible will not be considered an allowable expense, except for any health care expense incurred that may not be subject to the Deductible as described in Section 223 (c)(2)(C) of the Internal Revenue Code of 1986.
2. An expense that is not covered by any Plan covering you is not an Allowable Expense.
3. When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare’s allowable amount is the allowable expense.

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

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If you are covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If you are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. The amount of any benefit reduction by the Primary Plan because a Member has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second Surgical opinions, precertification of admissions, and preferred Provider arrangements.

Closed Panel Plan is a Plan that provides health care benefits to you in the form of services through a panel of Providers who are primarily employed by the Plan, and that

excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel Member.

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

Order of Benefit Determination Rules

When you are covered by two or more plans, the rules for determining the order of benefit payments are as follows. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan. A plan that does not contain a coordination of benefits provision that is consistent with chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both Plans state that the complying plan is primary, with the exception of coverage that is obtained by virtue of membership in a group that is designed to supplement part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the Contract holder. Examples include major medical coverage that are superimposed over Hospital and Surgical benefits, and insurance type coverage that are written in connection with a Closed Panel Plan to provide out-of-network benefits. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan. Each Plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent

The plan that covers you other than as a dependent, (for example as an employee, Member, Contract holder, Subscriber or retiree) is the Primary Plan and the Plan that covers you as a dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a dependent, and primary to the Plan covering you as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering you as an employee, Member, Contract holder, Subscriber or retiree is the Secondary Plan and the other plan is the Primary Plan.

Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, when a child is covered by more than one Plan the order of benefits is determined as follows:

1. For a child whose parents are married or are living together, whether or not they have ever been married:
    a. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    b. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:

a. If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child’s health care expenses, but that parent’s Spouse does, then that parent’s Spouse’s plan is the Primary Plan. This rule applies to Claim determination periods commencing after the Plan is given notice of the court decree;

b. If a court decree states one parent is to assume primary financial responsibility for the child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

c. If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits;

d. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits; or

e. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

   i. The Plan covering the Custodial Parent, first;

   ii. The Plan covering the Spouse of the Custodial Parent, second;

   iii. The Plan covering the non-custodial parent, third; and then

   iv. The Plan covering the Spouse of the non-custodial parent, last.

3. For a child covered under more than one Plan of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for child(ren) whose parents are married or are living together or for child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

Active Employee or Retired or Laid-off Employee

The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a dependent of an active employee and you are a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the **Non-Dependent or Dependent** provision above can determine the order of benefits.

COBRA or State Continuation Coverage

If your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering you as an employee, Member, Subscriber or retiree or covering you as a dependent of an employee, Member, Subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the **Non-Dependent or Dependent** provision above can determine the order of benefits.

Longer or Shorter Length of Coverage

The Plan that covered you as an employee, Member, Contract holder, Subscriber or retiree longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan. If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any Claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the Claim equal 100 percent of the total Allowable Expense for the Claim. Total Allowable Expense is the highest Allowable Expense of the Primary Plan or the Secondary Plan. In addition, the Secondary Plan must credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage. If this plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering you. We need not tell, or get the consent of, any person to do this. To claim benefits under this Plan, you must give us any facts we need to apply those rules and determine benefits payable.

Facility of Payment

If payments that should have been paid by us are paid by another plan, we have the right, at our discretion, to remit to the other Plan the amount we determine appropriate to satisfy the intent of this provision. The amounts paid to the other plan are considered benefits paid by us. To the extent of such payments, we are fully discharged from liability under this plan.

Right of Recovery

We have the right to recover excess payment whenever we have paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. We may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans. If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your Network Provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within 30 calendar days.

Effect of Medicare

Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status and will be adjudicated by us as set forth in this section. When Medicare, Part A and Part B or Part C is primary, Medicare's allowable amount is the highest allowable expense.

When a person is eligible for Medicare benefits, and Medicare is deemed to be the primary bill payer under Medicare secondary payer guidelines and regulations, we will reduce our payment by the Medicare primary payment and pay as secondary up to the Medicare allowable amount. However, under no circumstances will this plan pay more than it would have paid if it had been the Primary Plan.

Members may no longer be eligible to receive a premium subsidy for the Washington Health Benefit Exchange plan once Medicare coverage becomes effective.

CAUTION: All health plans have timely Claim filing requirements. If you or your Provider fail(s) to submit your Claim to a secondary health plan within that plan's Claim filing time limit, the plan can deny the Claim. If you experience delays in the processing of your Claim by the primary health plan, you or your Provider will need to submit your Claim to the secondary health plan within its Claim filing time limit to prevent a denial of the Claim. To avoid delays in Claim processing, if you are covered by more than one plan you should promptly report to your Providers and plans any changes in your coverage. If you have questions about this Coordination of Benefits provision, please contact the Washington State Office of the Insurance Commissioner.

CLAIMS

Your health care benefits are paid according to the conditions in this section. If you paid Providers for services this section will outline the process you should follow if you need to be reimbursed.

Generally, you will not have any Claims to file or Claim forms to fill out for medical services received from Network Providers. Your Network Provider will bill us directly. However, most Covered Services do require a Cost Sharing amount. Please refer to the **COST SHARING** section of this Contract and your Schedule of Benefits for your Cost Sharing responsibility.

Notice of Claim

We must receive notice of Claim within 30 calendar days of the date the loss began or as soon as reasonably possible.

In no event, except the absence of legal capacity, shall a Claim be accepted later than one year from the date of service.

Services from Network Providers

We pay Network Providers directly for Covered Services provided to Members. You should not be required to pay sums to a Network Provider for Covered Services except for required Cost Sharing amounts. You will be responsible for payment of charges for missed appointments or appointments canceled without adequate notice.

If you are asked by a Network Provider to make any payments for Covered Services in addition to the Cost Sharing amounts in this Contract or your Schedule of Benefits, you should contact Member Services before making any additional payments. You are not liable to a Network Provider for any amounts that we owe the Provider.

If you receive a bill for services you believe are covered under this Contract, you must within 90 calendar days of the date of service, or as soon thereafter as reasonably possible, either:

1. Contact Member Services. If a Claim has already been submitted to Ambetter by your Provider, we can provide information about its status. If we have not received a Claim, we will work with you or your Provider to obtain one; or
2. If you have already paid the bill, you can submit a Claim for reimbursement of Covered Services to:

Ambetter from Coordinated Care
Attn: Claims Department – Member Reimbursement
P.O. Box 5010
Farmington, MO 63640-5010

The Member Reimbursement Medical Claim Form may be found online at AmbetterHealth.com/en/WA.

Services from Non-Network Providers

Except for emergency medical services and non-emergency Surgical or Ancillary Services (emergency medicine, anesthesiology, pathology, radiology, neonatology, Surgery, hospitalist, intensivist, as well as diagnostic services (including radiology and laboratory services)) received at a Network Hospital or Network Ambulatory Surgical Center and air or ground ambulance for an Emergency Medical Condition, you must receive Prior Authorization before receiving services from a Non-Network Provider. Otherwise, you may be responsible for all charges incurred.

If you receive Authorization to obtain services from a Non-Network Provider you may be required to make full payment to the Non-Network Provider at the time services are rendered. You should then submit satisfactory evidence to us that such payment was made to the Non-Network Provider. Upon review and approval of the evidence of payment, we will reimburse you for Covered Services less any required Cost Sharing that you would have been required to pay had the services been obtained from a Network Provider. You will be responsible for any charges not specifically Authorized or covered by us. Alternatively, you may also ask the Provider to submit a Claim to us for payment.

Emergency Services from Non-Network Providers

If you receive Emergency Services due to an Emergency Medical Condition from a Non-Network Provider, please ask your Provider to submit a Claim to Ambetter from Coordinated Care for the services rendered. If your Provider is unwilling to submit a Claim, you are responsible for submitting the Claim. The Claim must contain an itemized statement of treatment, expenses, and diagnosis, as well as any other information that we request in the process of handling your Claim. If you are submitting the Claim, then the itemized Claim or statement must be submitted to us as soon as possible at the following address:

Ambetter from Coordinated Care
Attn: Claims Department – Member Reimbursement
P.O. Box 5010
Farmington, MO 63640-5010

Upon review and approval of the evidence of payment, we will reimburse you the Eligible Expense amount for Covered Services less any required Cost Sharing that you would have been required to pay had the services been obtained from a Network Provider. Depending on the circumstances, we may also pay the Claim to the Provider and ask the Provider to reimburse you. You may be responsible for charges not specifically covered by us.

Note: The bill you receive for services or supplies from a Non-Network Provider may be significantly higher than the Eligible Expenses for those services or supplies. In addition to the Deductible Amount, Copayment Amount, and/or Coinsurance Amount, you are responsible for the difference between the Eligible Expense and the amount the Non-Network Provider bills you for the services or supplies not subject to Balance Billing Protections as described in the **DEFINITIONS** section of this Contract. Any amount you are obligated to pay to the Non-Network Provider in excess of the Eligible Expense will not apply to your Deductible Amount or Maximum Out-of-Pocket Amount. Charges you incur for Covered Services from a Non-Network Provider in a Network Facility for covered non-network Emergency Services and air or

ground ambulance services subject to Balance Billing Protections will accumulate towards your Network Deductible and/or Maximum Out-of-Pocket Amount indicated in your Schedule of Benefits.

Cooperation Provision

Each Member, or other person acting on the Member's behalf, must cooperate fully to assist us in determining our rights and obligations under the Contract and, as often as may be reasonably necessary:

1. Sign, date and deliver to us authorizations to obtain any medical or other information, records or documents.
2. Obtain and furnish to us, or our representatives, medical or other information, records or documents.
3. Answer, under oath or otherwise, any questions which we or our representatives may ask.
4. Furnish any other information, or assistance that we may require, including assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to us, or our representative, any information, records or documents needed for review).

If any Member, or other person acting on the Member's behalf, fails to provide any of the items or information requested or to take any action requested, the Claim(s) will be closed and no further action will be taken by us unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the Contract.

Claims Incurred for Emergency Services While Traveling Outside the United States

Medical Emergency Services are covered for up to 90 consecutive days while traveling outside the United States. If travel extends beyond 90 consecutive days, no benefit coverage is provided for Emergency Services the entire period of travel, including the first 90 calendar days.

Claims incurred outside of the United States for Emergency Services must be submitted within 180 calendar days from the date of service. The claims must include clinical documentation (medical records) that supports all Emergency Services received. Claims and medical records must be submitted in English or with an English translation, at the Member's expense to show proper proof of loss and evidence of any payment(s) to the provider. Proof of departure from and arrival to the United States must be submitted with the claim. These documents must be submitted with the Member Reimbursement Medical Claim Form, along with all requested documents as detailed on the Claim form. All forms and Member resources are available at AmbetterHealth.com/en/WA.

Reimbursement for covered Emergency Services (less the Member's Cost Share responsibility) will be sent to the Member, who is responsible for paying the provider. Such payment will fulfill our obligation to the Member for the Emergency Services. Reimbursement is based on the Member's benefit plan, Cost Share, and currency exchange rate at the time of

the transaction. The Explanation of Benefits will detail the Member's responsibility and any eligible reimbursement.

Custodial Parent

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

Upon request by the custodial parent, we will:

1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the Contract;
2. Accept Claim forms and requests for Claim payment from the custodial parent; and
3. Make Claim payments directly to the custodial parent for Claims submitted by the custodial parent. Payment of Claims to the custodial parent, which are made under this provision, will fully discharge our obligations.

A custodial parent may, with our approval, assign Claim payments to the Hospital or Medical Practitioner providing treatment to an Eligible Child.

Right to Receive and Release Necessary Information and Medical Records

Your personal health information may be requested or disclosed by us if necessary to help you get medical care, to pay your Claims or for operational purposes like Care Management or to improve the quality of care you receive.

The following is a non-exclusive list of health care Providers and types of information that we may request or disclose to help in your treatment payment of your Claims or other operational purposes:

1. Other insurance carriers or group health plans;
2. Any other institution providing care, treatment, consultation, drugs or supplies;
3. Clinics, Hospitals, long-term care or other medical Facility; or
4. Physicians, dentists, pharmacists or other physical or Behavioral Health care Providers;
5. Billing statements;
6. Claim records;
7. Correspondence;
8. Dental records;
9. Diagnostic imaging reports;
10. Hospital records (including nursing records and progress notes);
11. Laboratory reports; and

12. Medical records.

We are required by law to protect your personal and health information. We must obtain prior written authorization from you before we release any information not related to routine treatment, payment and operational purposes. You may request a copy of our Notice of Privacy Practices by calling Member Services or visiting our website at AmbetterHealth.com/en/WA.

Non-Assignment

The coverage, rights, privileges and benefits provided for under this Contract are not assignable by you or anyone acting on your behalf. Any assignment or purported assignment of coverage, rights, privileges and benefits provided for under this Contract that you may provide or execute in favor of any Hospital, Provider, or any other person or entity shall be null and void and shall not impose any obligation on us.

No Third-Party Beneficiaries

This Contract is not intended to, nor does it, create or grant any rights in favor of any third-party, including but not limited to any Hospital, Provider or Medical Practitioner providing services to you. This Contract shall not be construed to create any third-party beneficiary rights.

GRIEVANCE AND APPEAL PROCESS

We hope you will always be satisfied with us and our Providers. If you are not satisfied, please let us know. We offer the following processes if you are dissatisfied with the services you receive or a decision that we make:

1. Grievance Process – use this process to express a Complaint or dissatisfaction about customer service or the quality or availability of a health service.
2. Appeal Process – use this process to ask us to internally reconsider a decision (Adverse Benefit Determination) we made regarding your benefits or a Claim.
3. External Review by an Independent Review Organization – this process is available for Members who are not satisfied with the final outcome of the internal Appeal process.

Ambetter from Coordinated Care will assist you through the Grievance or Appeal process and will respond in a timely and thorough manner. We will ensure that the processes are accessible to Members who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that affect their ability to file a Grievance or an Appeal.

We will not retaliate against you or your Representative for filing a Grievance or an Appeal. We will not take, or threaten to take, any punitive action against a Provider acting on behalf or in support of any Member filing a Grievance or Appeal.

Representative means someone who represents you for the purpose of an Appeal or Grievance. The Representative may be your treating Provider or can be another party, such as a family member or friend, as long as you or your legal guardian authorize, in writing, our disclosure of your protected health information for the purpose of the Appeal or Grievance. No authorization is required from the parent(s) or legal guardian of a Member who is an unmarried and dependent child and is less than 14 years old. A Medical Practitioner with knowledge of your medical condition is recognized as your Representative and can request an internal Appeal of a Prior Authorization denial on your behalf without your consent. Even if you have previously designated a person as your Representative in a previous Appeal, an authorization designating that person as your Representative in a new Appeal will be required (but re-designation is not required for each Appeal level). If no authorization exists and is not received during the course of an Appeal, the determination and any personal information will only be disclosed to you and your treating Provider.

Grievance Process

Ambetter from Coordinated Care strives to ensure that all interactions are positive and takes seriously any expression of dissatisfaction. Grievances can be related to health plan customer service or the quality or availability of a health service. Many Grievances can be resolved immediately on the phone. Ambetter from Coordinated Care will work to fully document, investigate and resolve any of your questions, concerns and Grievances.

How to File a Grievance

Filing a Grievance will not affect your health care services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services. A written Grievance may be mailed, faxed or e-mailed to Ambetter from Coordinated Care at:

Ambetter from Coordinated Care
Attn: Grievance Department
P.O. Box 10341
Van Nuys, CA 91410
Telephone: 1-877-687-1197 (TTY 711)
Fax: 1-833-886-7956
E-mail: Ambetter_centralized_grievances_appeals@centene.com

A Member Grievance Form may be found online at AmbetterHealth.com/en/WA. Be sure to include:

1. Your first and last name.
2. Your Member ID number.
3. Your address and telephone number.
4. What you are unhappy with.
5. Any supporting documentation, (e.g., date and location of service, Claim number, Provider name, etc.).
6. What you would like to have happen (desired outcome).

You have up to **180 calendar days** to file a Grievance. The 180 calendar days begins on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can.

The Grievance Department will send you a letter within 5 business days of receiving your Grievance if the Member Service representative was not able to resolve the Grievance with you on the phone or if you sent a written Grievance to us. The letter will let you know that we have received your Grievance and the expected date of resolution. The letter serves as both a written record of your Grievance as well as an acknowledgement.

If someone else is going to file a Grievance for you, we must have your written permission for that person to file a Grievance on your behalf. You will need to obtain and fill out an Authorization to Disclose Health Information Form and return it to us so that we will know who you have granted permission to represent you. The Authorization to Disclose Health Information Form can be obtained by calling Member Services or by visiting our website at AmbetterHealth.com/en/WA. If a signed Authorization to Disclose Health Information form is not included with your Grievance, a form will be sent to you for your signature with the acknowledgement letter. If a signed Authorization is not returned to us within 14 calendar days of it being sent to you, we will close the Grievance without resolution.

If you have any proof or information that supports your Grievance, you may send it to us and we will add it to your case. You may supply this information to Ambetter from Coordinated Care by email, fax, in person, or other written method. You may also request to receive copies of any documentation that Ambetter from Coordinated Care used to make the decision about your Grievance. We may need to obtain additional information to review your request.

Some Grievances are resolved immediately when you call Member Services. If it cannot be resolved immediately, or if you send us a written Grievance, you can expect a written resolution within 30 calendar days of our receipt of your Grievance. If we need more time to review, we may extend up to an additional 14 calendar days and will provide a written notice of the reason for the delay.

Appeal Process

You or your Authorized Representative may file an Appeal when you wish us to reconsider a decision (Adverse Benefit Determination) we made regarding health care benefits, services or Claims.

An Adverse Benefit Determination is a decision we made, based on review of information that was provided, to deny, reduce, modify or terminate payment, coverage, Authorization or provision of health care services or benefits, including the admission to or continued stay in a health care Facility. If we deny a Prior Authorization request, your Provider may Appeal the denial on your behalf without your written consent.

If you have an Appeal about eligibility, your Appeal should be filed with the Washington Health Benefit Exchange or us. Under federal law, the entity through which you enrolled (Exchange or us) is responsible for all eligibility decisions. If your Appeal involves your eligibility or enrollment, please contact the Exchange at 1-855-923-4633 or visit www.wahbexchange.org. If you enrolled directly with us, please contact Member Services.

How to File an Internal Appeal

Once you receive or learn of a decision of an Adverse Benefit Determination by us that you would like us to reconsider, you may file an internal Appeal. Internal Appeals are handled within Ambetter from Coordinated Care and will be reviewed by people who were not involved in making the decision you are Appealing. Your internal Appeal may be reviewed as either a standard internal Appeal or as an expedited internal Appeal. If an immediate decision is required due to your health needs, you, your Provider or your Authorized Representative may request an expedited internal Appeal.

Appeals can be initiated through either written or verbal request. You may file an Appeal by calling Member Services or your written Appeal may be mailed, faxed or e-mailed to Ambetter from Coordinated Care at:

Ambetter from Coordinated Care
Attn: Appeals Department
1145 Broadway, Suite 700
Tacoma, WA 98402
Telephone: 1-877-687-1197 (TTY 711)
Fax: 1-855-218-0589
Email: Tac_WAAppealDept@Centene.com

A Member Appeal Form may be found online at AmbetterHealth.com/en/WA. An acknowledgement letter will be sent within 72 hours of receipt of the internal Appeal.

Internal Appeals, including expedited internal Appeals, must be pursued within 180 calendar days of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal and a review by an Independent Review Organization concurrently. Please see **Expedited Appeals** later in this section for more information.

Internal Appeal Continuation of Care

If you are still receiving Covered Services that are under Appeal, the services may continue until a decision is made on the internal Appeal. You should notify us if you are currently receiving services under Appeal, and you would like to continue those services during the Appeal process. If the final decision in the Appeal process results in a denial, you may be responsible for the costs for services you received during the Appeal process.

Internal Appeal Review

The content of the internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your Authorized Representative will have the right to submit comments, documentation, records, and other information relevant to the internal Appeal in person or in writing. A Provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate the medical necessity decision of a final determination. You will be given a reasonable opportunity to provide written materials, including written testimony to support your Appeal. Ambetter from Coordinated Care will provide you, or your Authorized Representative, with written notification of our decision:

1. For a non-expedited internal Appeal, you will be notified of the outcome of the Appeal within 14 calendar days of receipt of the Appeal.
2. For Appeals involving an Experimental or Investigational treatment, you will be notified of our decision within 20 calendar days of receipt of the Appeal.
3. For good reason, we may extend the time by up to 16 additional calendar days without your or your Authorized Representative's written consent but will notify you or your Authorized Representative of the extension and reason for the extension. After the 16 additional calendar day extension, we may request additional time to review your Appeal but only if you or your Authorized Representative agree to our request for further extension. We will provide you or your Authorized Representative with written notice of a specific agreed-upon date for when we will provide our decision. Waiver of consent to the response time is not required.

Expedited Internal Appeal

Expedited Internal Appeal Qualifying Conditions

If your Provider feels that the matter being Appealed is urgent due to health needs which cannot wait the standard resolution time, an expedited internal Appeal may be requested.

Appeals regarding payment for services that have already been provided are not eligible for Expedited Appeals. An expedited internal Appeal may be requested if:

1. You are currently receiving or are prescribed treatment or benefits, including Prescription Drugs, for a medical condition that will end because of our Adverse Benefit Determination; or
2. Your treating Provider believes that a delay in treatment based on the application of standard Appeal timeframes on a pre-service or concurrent care could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject you to severe and intolerable pain; or
3. The Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged from the emergency room or transport service.

If we determine the above criteria have not been met, you will be notified and your Appeal will be processed using the standard appeal timelines.

Expedited Internal Appeal Submission

An expedited internal Appeal is requested in the same manner as a standard internal Appeal. For an expedited internal Appeal your treating Provider may act as your Authorized Representative without a signed written consent from you.

Expedited Internal Appeal Continuation of Care

If you are currently receiving Covered Services, you may continue to receive services at the expense of Ambetter from Coordinated Care through the completion of the expedited internal Appeal process if the expedited internal Appeal is filed timely and the service was previously Authorized by Ambetter from Coordinated Care.

Expedited Internal Appeal Review

The content of the expedited internal Appeal request including all clinical care aspects involved will be fully investigated and documented. You or your Authorized Representative will have the right to submit comments, documentation, records, and other information relevant to the expedited internal Appeal in person or in writing. A Provider or other appropriate clinical peer of a same-or-similar specialty will evaluate the medical necessity decision of a final determination. The decision will be made as expeditiously as possible for an expedited review request, preferably within 24 hours, but in no case longer than 72 hours from the request for Appeal.

Appeal Determination Notification

The written notification of resolution of your Appeal will include the specific reasons for the decision. If the Appeal was not decided in your favor, you may request External Review by an Independent Review Organization (IRO). Information for pursuing an External Review will be included in the Appeal Determination letter.

External Review

External Review Submission

If you are not satisfied with the final outcome of the internal Appeal, you may request External Review of the decision by an Independent Review Organization (IRO). You have 180 calendar days from the internal Appeal decision date to file a request for External Review. This includes, but is not limited to, decisions based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not effective or otherwise unjustified under evidence-based medical criteria. For requests involving Experimental or Investigational treatments, the IRO must ensure that adequate clinical and scientific experience and protocols are taken into account as part of the External Review process. There is no cost to you for requesting External Review.

You or your Authorized Representative may request External Review or Expedited External Review at the end of the internal Appeal process. Instructions for submitting the request will be included with the internal Appeal Determination Notification we send. Expedited External Review can be submitted at the same time the Member submits a request for an expedited internal Appeal. You will be provided with at least five business days to submit additional information to the IRO, in writing, that it must consider when conducting the External Review. Within one business day of receiving such additional information, the IRO will forward it to us.

Ambetter from Coordinated Care will work with you and the IRO. The decision made by an IRO is at no cost to you. We will provide the IRO with the denial and Appeal documentation. A written notice of the IRO's decision will be sent to you within 15 calendar days after the IRO receives the necessary information or 20 calendar days after the IRO receives the request.

External Review Continuation of Care

If you are still receiving Covered Services that are under External Review, the services may continue until a decision is made on the External Review. You should notify us if you are currently receiving services under External Review, and you would like to continue those services during the External Review process. If the final decision in the External Review process results in a denial, you may be responsible for the costs for services you received during the External Review process.

Expedited External Review

If you disagree with the decision made in the internal Expedited Appeal and you or your Representative reasonably believe that a pre-service or concurrent care Prior Authorization remains clinically urgent, you may request a voluntary Expedited Appeal to an IRO. The criteria for a voluntary Expedited Appeal to an IRO are the same as described above for non-urgent IRO review. You may request a voluntary Expedited External Appeal at the same time you request an Expedited Appeal from Ambetter from Coordinated Care.

For Expedited External Reviews, the IRO's decision will be provided to you and us as expeditiously as possible after the decision, but no later than within 72 hours of the IRO's receipt of the request. If the initial notice is not in writing, the Independent Review Organization must provide written confirmation of the decision within 48 hours after the date of the notice of the decision.

External Review by an IRO is the final Appeal level. Ambetter from Coordinated Care is bound by the IRO's decision, except to the extent other remedies are available under state or federal law. External Review by an IRO is optional and you should know that other forums may be utilized as the final level of Appeal to resolve a dispute you have with us. This includes but is not limited to civil action under Section 502(a) of ERISA, where applicable.

The U.S. Department of Health and Human Services has designated the Washington State Office of the Insurance Commissioner's Consumer Protection Division as the health insurance consumer ombudsman. The Consumer Protection Division Office can be reached by mail at Washington State Office of the Insurance Commissioner, Consumer Protection Division, P.O. Box 40255, Olympia, WA 98504-0255 or toll free at 1-800 562-6900. More information about requesting assistance from the Consumer Protection Division Office can be found at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status.

Expedited External Review Continuation of Care

If you are currently receiving Covered Services, you may continue to receive services at the expense of Ambetter from Coordinated Care through the completion of the Expedited External Review process if the Expedited External Review is filed timely and the service was previously Authorized by Ambetter from Coordinated Care. You should notify us if you are currently receiving services under External Review, and you would like to continue those services during the External Review process. If the final decision in the External Review process results in a denial, you may be responsible for the costs for services you received during the External Review process.

Information

If you have any questions about the Grievance and Appeal process outlined here, you may contact Member Services.

GENERAL PROVISIONS

Confidentiality

Each party acknowledges that performance of its obligations under this Contract may involve access to and disclosure of data, procedures, materials, lists, systems and information, including medical records, Member benefits information, Member addresses, social security numbers, e-mail addresses, phone numbers and other confidential information regarding the Member (collectively the “information”). The information shall be kept strictly confidential and shall not be disclosed to any third-party other than:

1. Representatives of the receiving party (as permitted by applicable state and federal law) who have a need to know such information in order to perform the services required of such party pursuant to this Contract or for the proper management and administration of the receiving party, provided that such Representatives are informed of the confidentiality provisions of this Contract and agree to abide by them,
2. pursuant to court order or
3. to a designated public official or agency pursuant to the requirements of federal, state or local law, statute, rule or regulation.

The disclosing party will provide the other party with prompt notice of any request the disclosing party receives to disclose information pursuant to applicable legal requirements, so that the other party may object to the request and/or seek an appropriate protective order against such request. Each party shall maintain the confidentiality of medical records and confidential patient and Member information as required by Applicable Law.

Entire Contract

This Contract, with the Schedule of Benefits and enrollment application, is the entire Contract between you and us. No agent may:

1. Change this Contract;
2. Waive any of the provisions of this Contract;
3. Extend the time for payment of premiums; or
4. Waive any of our rights or requirements.

Notices

Notices provided for in this Contract shall be mailed to us at our principal address and to the Members Residence address as it appears in our records. The Member shall notify us in writing of any changes in Residence within 30 calendar days of such change.

Compliance with Law

We and the Member shall comply with all applicable state and federal laws and regulations in performance of this Contract. This Contract is entered into and governed by the laws of Washington State, except as otherwise pre-empted by federal laws.

Modification of Contract

This Contract may be modified by us upon 30 calendar days written notice mailed to each Member at their Residence as it appears in our records. Failure to receive such notice shall not affect the modification or Effective Date thereof.

No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this Contract convey or void any coverage, increase or reduce any benefits under this Contract or be used in the prosecution or defense of a Claim under this Contract.

New Technology

Health technology is always changing. If we think a new medical advancement can benefit our Members, we evaluate it for coverage. These advancements include:

1. New technology
2. New medical procedures
3. New drugs
4. New devices
5. New application of existing technology

Sometimes, our medical director and/or medical management staff will identify technological advances that could benefit our Members. The Clinical Policy Committee (CPC) reviews requests for coverage and decides whether we should change any of our benefits to include the new technology.

If the CPC does not review a request for coverage of new technology, our Medical Director will review the request and make a one-time determination. The CPC may then review the new technology request at a future meeting.

Nondiscrimination

Ambetter from Coordinated Care does not discriminate on the basis of physical or mental disabilities in its employment practices and services.

Non-Waiver

If we or you fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the Contract, this will not be considered a waiver of any rights under the Contract. A past failure to strictly enforce the Contract will not be a waiver of any rights in the future, even in the same situation or set of facts.

Personal Health Information (PHI)

Your health information is personal. We are committed to do everything we can to protect it. Your privacy is also important to us. We have policies and procedures in place to protect your health records.

We protect all oral, written and electronic PHI. We follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit AmbetterHealth.com/en/WA or call Member Services.

We protect all of your PHI. We follow HIPAA to keep your health care information private.

Rescissions

No misrepresentation of fact made regarding a Member during the application process that relates to insurability will be used to void/rescind the coverage or deny a Claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a Member;
2. A copy of the application, and any amendments, has been furnished to the Member(s), or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to our determination to issue coverage to any Member. A Member's coverage will be voided/rescinded and Claims denied if that person performs an act or practice that constitutes fraud. “Rescind” has a retroactive effect and means the coverage was never in effect.

Repayment for Fraud, Misrepresentation or False Information

During the first two years a Member is covered under the Contract, if a Member commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any Member under this Contract or in filing a Claim for Contract benefits, we have the right to demand that Member pay back to us all benefits that we provided or paid during the time the Member was covered under the Contract.

Conformity with Applicable Laws

Any part of this Contract in conflict with Applicable Laws on this Contract's Effective Date or on any premium due date is changed to conform to the minimum requirements of Applicable Laws.

List of Available Disclosures

Have questions? Your Member handbook and this Evidence of Coverage (EOC) have answers. You will be able to find information about benefits, how to access care and important phone numbers. Your materials are located on your online Member account at AmbetterHealth.com/en/WA.

Upon request, you are entitled to the following:

1. A listing of Covered Services, including Prescription Drug benefits, a copy of the current Formulary, definitions of terms such as generic versus brand name, and policies

regarding coverage of drugs, such as how they become approved or taken off the Formulary, and how consumers may be involved in decisions about benefits;

2. A listing of exclusions, reductions, and limitations to Covered Services, and any definition of medical necessity or other coverage criteria upon which they may be based;
3. A statement of our policies for protecting the confidentiality of health information;
4. A statement of the cost of premiums and any Member Cost Sharing requirements;
5. A summary explanation of our review of Adverse Benefit Determinations and Grievance processes;
6. A statement regarding the availability of a point-of-service option, if any, and how the option operates;
7. A convenient means of obtaining lists of participating primary care and specialty care Providers, including disclosure of Network arrangements that restrict access to Providers within any plan Network.

Upon request, you are entitled to the following written information:

1. Any documents or other information referred to in the Evidence of Coverage (EOC);
2. A full description of the procedures to be followed by you for consulting a Provider other than your Primary Care Provider and whether a Prior Authorization is required;
3. Procedures to be followed by you for obtaining Prior Authorization for health care services;
4. A written description of any reimbursement or payment arrangements between the issuer and Providers, including capitation provisions, fee-for-service provisions and health care delivery efficiency provisions;
5. Descriptions and justifications for Provider compensation programs, including any incentives or penalties that are intended to encourage Providers to withhold services or minimize or avoid Authorizations to Specialist Providers;
6. An annual accounting of payments made by us which have been counted against any payment limitations, visit limitations, or other overall limitations on your coverage under this plan;
7. A copy of our review of Adverse Benefit Determinations for Claim or service denial and our Grievance process for dissatisfaction with care;
8. Accreditation status with a NCQA, and information regarding whether we track our health care effectiveness performance using Health Care Effectiveness Data and Information Set (HEDIS), if this information is publicly available and how many people can access HEDIS data.

Upon request, you are also entitled to access:

1. Copies of all documents, records, and other information relevant to a Claim.
2. The criteria, processes, strategies, evidentiary standards and other factors used to make medical necessity determinations of mental health or Substance Use Disorder

benefits. This includes information on the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/Surgical and mental health or Substance Use Disorder benefits under the health plan.

This list is also available in the Member Resources section at AmbetterHealth.com/en/WA.