

**Celtic Insurance Company
Ambetter from Sunshine Health**

Home Office: 77 West Wacker Drive, Suite 1200, Chicago, IL 60601

Individual Member Contract

In this *contract*, "you", "your", "yours" or "member" will refer to the subscriber and/or any Dependents named on the Schedule of Benefits, and "we," "our," or "us" will refer to Celtic Insurance Company.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is made a part of the *contract*. We will provide benefits to *you*, the *member*, for covered benefits as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

This *contract* is guaranteed renewable. *You* may keep this *contract* in force by timely payment of the required premiums. Coverage under this *contract* is for an initial term of 12 months commencing as of the *effective date* of the *member's* coverage and will automatically renew for successive terms of 12 months unless terminated or non-renewed as provided for in this *contract*. However, *we* may refuse renewal as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all *contracts* issued on this form, with the same type and level of benefits, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

Rate changes are effective on a *member's* annual renewal date and will be based on each *member's* attained age, family structure, geographic region, tobacco usage and benefit plan at the time of renewal. We have the right to change premiums. We will notify the *member* in writing at least 45 days prior to the renewal date of any change in premium rates. If *we* discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, *we* will provide a written notice to you at least 90 days prior to the date that *we* discontinue coverage.

At least 45 days advanced written notice of any plan to take an action or make a change permitted by this clause will be 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.

TEN DAY 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 days after you receive it. All premiums paid will be refunded, less any benefits paid, and the *contract* will be considered null and void from the effective date.

This *contract* contains a deductible provision

As a cost containment feature, this *contract* contains prior authorization requirements. This *contract* may require a referral from a primary care physician for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

[Celtic Insurance Company

A handwritten signature in black ink, consisting of several overlapping loops and a long horizontal stroke at the bottom.

Anand Shukla, Senior Vice President

Individual Health]

TABLE OF CONTENTS

Contract Face Page.....	1
Introduction.....	4
Member Rights and Responsibilities.....	5
Definitions.....	9
Dependent Member Coverage.....	24
Ongoing Eligibility.....	26
Premiums.....	28
Major Medical Expense Benefits.....	29
Prior Authorization.....	43
General Non-Covered Services and Exclusions.....	44
Plan Administration.....	47
Reimbursement.....	51
Coordination of Benefits.....	52
Claims.....	55
Grievance and Complaint Procedures.....	57
General Provisions.....	64
Attachment: Plan Information Page Schedule of Benefits	

INTRODUCTION

Welcome to Ambetter from Sunshine Health! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services. It describes:

- How to access medical care.
- What health services are covered by *us*.
- What portion of the health care costs *you* will be required to pay.

This *contract*, the Schedule of Benefits, the application as submitted to 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*.

This *contract* should be read and re-read in its entirety. Since many of the provisions of this *contract* are interrelated, you should read the entire *contract* to get a full understanding of your coverage. Many words used in the *contract* have special meanings, are *italicized* and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. This *contract* also contains exclusions, so please be sure to read this *contract* carefully.

How to Contact Us

Ambetter from Sunshine Health
1301 International Parkway, Suite 400
Sunrise, FL 33323

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST

Member Services 1-877-687-1169
TDD/TTY line 1-800-955-8770
Fax 1-866-796-0523
Emergency **911**

24/7 Nurse Advice Line 1-877-687-1169 **(24 hour nurse advice line)**

Interpreter Services

Ambetter from Sunshine Health has a free service to help *our members* who speak languages other than English. This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand. *Our* interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at 1-877-687-1169 (TDD/TTY 1-800-955-8770).

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 *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 age, ethnicity or race, religion, gender, sexual orientation, national origin, physical or mental disability, and/or expected health or genetic status.

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, 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 surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is 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.
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 or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* 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 or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, 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 person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding member's rights, responsibilities and policies.
9. Voice complaints or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician(s)* of the medical consequences.
11. Participate in matters of the organization's policy and operations.
12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and *our* other rules and

guidelines. *We will notify you at least 60 days before the effective date of the modifications. Such notices shall include:*

- a. Any changes in clinical review criteria; or
 - b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
14. A current list of *network providers*. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
 15. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
 16. Access *medically necessary* urgent and *emergency* services 24 hours a day, seven days a week.
 17. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
 18. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care physician's* instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
 19. Select your *primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
 20. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
 21. An interpreter when *you* do not speak or understand the language of the area.
 22. A second opinion by a *network provider*, at no cost to *you*, or non- *network provider* and *you* will be responsible for up to 40 percent of the cost, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
 23. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
 24. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help your *primary care physician* 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; and
 - 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.

You have the responsibility to:

1. Read this *contract* in its entirety.
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. *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.

5. Show *your* member ID 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. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. *You* may change *your primary care physician* verbally or in writing by contacting *our* Member Services Department.
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. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. 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 *primary care physician* 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.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. When *you* enroll in this coverage, give all information about any other medical coverage *you* have. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell *us*.
15. Pay *your* monthly premium, all *deductible amounts*, *copayment amounts*, or *cost-sharing percentages* at the time of service.

NOTE: Let *our* Member Service Department know if *you* have any changes to *your* name, address, or family members covered under this *contract*.

Your Provider Directory

A listing of *network providers* is available online at www.ambetter.sunshinehealth.com. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. *You* may find any of our *network providers* by completing the "Find a Doctor" function on *our* website and selecting Ambetter from Sunshine Health. There *you* will have the ability to narrow *your* search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. *Your* search will produce a list of providers based on *your* search criteria and will give *you* other information such as address, phone number, office hours, and qualifications.

At any time, *you* can request a copy of the provider directory at no charge by calling Member Services at 1-877-687-1169. In order to obtain benefits, *you* may be required to designate a *network primary care physician* for each *member*. *We* can also help *you* choose a *primary care physician*. *We* can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician's* office if you want to make an appointment. If *you* need help, call Member

Services at 1-877-687-1169. *We will help you make the appointment.*

Your Member ID Card

When *you* enroll, *we* will mail a member ID card to *you* within 5 business days of *our* receipt of *your* enrollment materials. This card is proof that *you* are enrolled in the Ambetter plan. *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 ID card will show *your* name, *member* ID#, the phone number for Behavioral Health services, and *copayment amounts* required at the time of service. If *you* do not get your member ID card within a few weeks after *you* enroll, please call Member Services at 1-877-687-1169. *We* will send *you* another card.

Our Website

Our website helps *you* get the answers to many of *your* frequently asked questions. *Our* website has resources and features that make it easy to get quality care. *Our* website can be accessed at www.ambetter.sunshinehealth.com. It also gives *you* information on *your* benefits and services such as:

1. Finding a *physician*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. Member Rights and Responsibilities.
6. Notice of Privacy.
7. Current events and news.

Quality Improvement

We are committed to providing quality healthcare 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 Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, *our* programs include:

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening, and immunizations.
5. Monitoring the quality of care and developing action plans to improve the healthcare *you* are receiving.
6. A Quality Improvement Committee which includes *network providers* to help us develop and monitor our program activities.
7. Investigating any *member* concerns regarding care received.

For example, if *you* have a concern about the care *you* received from your *network physician* or service provided by *us*, please contact our Member Services Department.

We believe that getting *member* input can help make the content and quality of *our* programs better. *We* conduct a *member* survey each year that asks questions about *your* experience with the healthcare and

services *you* are receiving.

DEFINITIONS

In this *contract*, italicized words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this *contract*:

Acute rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for three or more hours per day, five to seven days per week, while the covered person is confined as an inpatient in a hospital, rehabilitation facility, or *extended care facility*.

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 premium tax credits can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance premium tax credit to apply to your premiums each month, up to a maximum amount. If the amount of advance premium tax credits you receive for the year is less than the total premium tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If the amount of advance premium tax credits you receive for the year is more than the total tax credit that you're due, you must repay the excess advance premium tax credit with your tax return.

Adverse benefit determination means:

Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:

1. Deductible credits; coinsurance; copayment amounts; network provider reductions or exclusions, or other cost sharing requirements;
2. Any instance where the plan pays less than the allowable amount to the member, resulting in member liability greater than what is defined in the member's deductible and copays;
3. A benefit resulting from the application of any utilization review;
4. A covered benefit that is otherwise denied as not medically necessary or appropriate;
5. A covered benefit that is otherwise denied as experimental or investigational;
6. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
7. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.
8. It also includes, for individual insurance products, a policy *reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

Allogeneic bone marrow transplant or **BMT** means a procedure in which bone marrow from a related or non-related donor is infused into the transplant recipient and includes peripheral blood stem cell transplants.

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.

Autologous bone marrow transplant or **ABMT** means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

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.

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of *listed transplants* or other services such as cancer, bariatric or infertility; and
2. Has agreed with *us* or an entity designated by *us* to meet quality of care criteria on a cost efficient basis. The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence*.

Child Health Supervision Services means physician-delivered or physician-supervised services that include the services described in the Major Medical Expense section of this *contract*. These services do not include hospital charges.

Chiropractic Care involves neuromuscular treatment in the form of manipulation and adjustment of the tissues of the body, particularly of the spinal column and may include physical medicine modalities or use of *durable medical equipment*.

Clinical Peer or same-or-similar specialist is a health care practitioner who has appropriate training and experience in the field of medicine involved in a utilization management appeal case. Same specialty refers to a provider with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. Similar specialty refers to a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.

Complaint means any expression of dissatisfaction expressed to the insurer by the claimant, or a claimant's authorized representative, about an insurer or its providers with whom the insurer has 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: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.

2. An *emergency caesarean section* or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness or injury*. The first *covered service expense* for the *illness or injury* must have been incurred before coverage of the *member* ceased under this *contract*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness or injury* will be determined by us based on generally accepted current medical practice.

Contract when *italicized*, means this *contract* issued and delivered to *you*. It includes the attached pages, including the Plan Information Page, Schedule of Benefits and any amendments.

Copayment amount means the amount of *covered services* that must be paid by a covered person for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered services* for that particular service under the *contract* of any *cost sharing percentage*.

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

Cost sharing percentage means the percentage of *covered services* that is payable by *us*.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

Covered service or **covered service expenses** means services, supplies or treatment as described in this *contract* which are performed, prescribed, directed or authorized by a *physician*. To be a *covered service* the service, supply or treatment must be

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

Custodial care is 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 amount means the amount of *covered expenses*, shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount*. The family deductible amount is two times the individual

deductible amount. For family coverage, the family deductible amount can be met with the combination of any one or more covered persons' *eligible service expenses*.

The *deductible amount* does not include any *copayment amounts*.

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 *your* lawful *spouse* and/or an *eligible child*.

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.

Effective date means the applicable date a *member* becomes covered under this *contract* for *covered services*. The applicable *effective date* is shown:

1. On the Schedule of Benefits for this *contract* for initial *members*; and
2. On the date *we* approve the addition of any new *member*.

Eligible child means the child of a covered person, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption;
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*. It is *your* responsibility to notify the Exchange 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*;
5. An unmarried child from the first of the month following the month in which the child turns age twenty-six (26) until the end of the calendar year in which the child turns thirty (30) years of age; and who is a resident of Florida or a full-time or part-time student; and is not provided coverage as a named member under any other group or individual health benefit plan; or is not entitled to benefits under Title XVIII of the Social Security Act.

If a dependent child is provided coverage under the subscriber's contract after the child reaches age twenty-six (26) and the coverage for the child is subsequently terminated prior to the end of the Calendar Year in which the child turns age thirty (30), the child is ineligible to be covered again under the Subscriber's Contract unless the child was continuously covered by other creditable coverage without a coverage gap of more than sixty-three (63) days.

Eligible service expense means a *covered service* as determined below.

1. For *network providers* : When a *covered service* is received from a *network provider*, the *eligible service expense* is the contracted fee with that provider.
2. For non-*network providers*:
 - a. When a *covered service* is received from a *non-network provider* as a result of an *emergency* and there is not a *network provider* reasonably accessible to render the *covered service*, the *eligible service expense* is the lesser of (1) 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), or (2) the provider's billed charge.;

- b. When a *covered service* is received from a *non-network provider* as a result of an *emergency* and there is a *network provider* reasonably accessible to render the *covered service*, the *eligible service expense* is the negotiated fee, if any, that the provider has agreed to accept as payment in full (*you* will not be billed for the difference between the negotiated fee and the provider's charge). However, if the provider has not agreed to accept a negotiated fee as payment in full, the eligible expense is the greatest of the following:
- i. the amount that would be paid under Medicare,
 - ii. the amount for the covered service calculated using the same method we generally use to determine payments for out-of-network services, or
 - iii. the contracted amount paid to *network providers* for the covered service. If there is more than one contracted amount with *network providers* for the covered service, the amount is the median of these amounts.

You may be billed for the difference between the amount paid and the provider's charge.

- c. When a *covered service* is received from a *non-network provider* as approved or authorized by *us*, the *eligible service expense* is the negotiated fee, if any, that the provider has agreed to accept 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 *eligible service expense* is the greater of (1) the amount that would be paid by Medicare, or (2) the contracted amount paid to *network providers* for the covered service. If there is more than one contracted amount with *network providers* for the covered service, the amount is the median of these amounts. *You* may be billed for the difference between the amount paid and the provider's charge.
- d. When a *covered service expense* is received from a *non-network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible service expense* is the negotiated fee, if any, that the provider has agreed to accept 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 *eligible service expense* is the amount that would be paid by Medicare. *You* may be billed for the difference between the amount paid and the provider's charge.
- law.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) which requires immediate (no later than 24 hours after onset) medical or surgical care and such that an average person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the *member* (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

With Respect to a pregnant woman:

1. that there is inadequate time to effect a safe transfer to another hospital prior to delivery;
2. that the transfer may pose a threat to the health and safety of the patient or fetus; or
3. that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Emergency services and care shall mean medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if any emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

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, including oral and 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

Expedited grievance means a *grievance* where any of the following applies:

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the *claimant* or the ability of the claimant to regain maximum function.
2. In the opinion of a physician with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*.
3. A physician with knowledge of the claimant's medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

Experimental or investigational treatment means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, we determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("*FDA*") regulation, regardless of whether the trial is subject to *FDA* oversight.
2. An *unproven service*.
3. Subject to *FDA* approval, and:
 - a. It does not have *FDA* approval;
 - b. It has *FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
 - c. It has *FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *FDA*-approved drug is a use that is determined by us to be:
 - i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
 - ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
 - iii. Not an *unproven service*.
 - d. It has *FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member*.
4. Experimental or investigational according to the provider's research protocols.

Items (3) and (4) above do not apply to phase I, II, III or IV *FDA* clinical trials.

Extended care facility means an institution, or a distinct part of an institution, that:

1. Is licensed as a *hospital, extended care facility, or rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective utilization review plan;
5. Provides each patient with a planned program of observation prescribed by a *physician*; and
6. Provides each patient with active treatment of an *illness or injury*, in accordance with existing generally accepted standards of medical practice for that condition.

Extended care facility does not include a facility primarily for rest, the aged, treatment of *substance abuse, custodial care, nursing care, or for care of mental disorders* or the mentally incompetent.

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards based on physician specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service* under the *policy*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

Grievance means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, a claimant including any of the following:

1. Provision of services;
2. Determination to reform or rescind a policy;
3. Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders; and
4. Claims practices.

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

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 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 care agency means a public or private agency, or one of its subdivisions, that:

1. Operates pursuant to law as a *home health care agency*;
2. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;

3. Maintains a daily medical record on each patient; and
4. Provides each patient with a planned program of observation and treatment by a *physician*, in accordance with existing 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 an institution that:

1. Provides a *hospice care program*;
2. Is separated from or operated as a separate unit of a *hospital*, *hospital-related institution*, *home health care agency*, mental health facility, *extended care facility*, or any other licensed health care institution;
3. Provides care for the *terminally ill*; and
4. Is licensed by the state in which it operates.

Hospice care program means a coordinated, interdisciplinary program prescribed and supervised by a *physician* to meet the special physical, psychological, and social needs of a *terminally ill member* and those of his or her *immediate family*.

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, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

This includes services of an osteopathic hospital when services are available in the service area.

Illness means a sickness, disease, or disorder of a *member*. *Illness* does not include learning disabilities, attitudinal disorders, or disciplinary problems. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

Immediate family means the parents, *spouse*, children, or siblings of any *member*, or any person residing with a *member*.

Injury means accidental bodily damage sustained by a *member* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

Inpatient means that medical services, supplies, or treatment 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 Cardiac Care Unit, or other 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 medical practitioners* and performed for three or more hours per day, five to seven days per week.

Listed transplant means one of the following procedures and no others:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
 - a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
 - b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
 - c. *BMT* for Severe Aplastic Anemia.
 - d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
 - e. *BMT* for Chronic Myelogenous Leukemia.
 - f. *ABMT* for Testicular Cancer.
 - g. *BMT* for Severe Combined Immunodeficiency.
 - h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
 - i. *BMT* for Myelodysplastic Syndrome.
 - j. *BMT* for Wiskott-Aldrich Syndrome.
 - k. *BMT* for Thalassemia Major.
 - l. *BMT* or *ABMT* for Multiple Myeloma.
 - m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabdomyosarcoma, medulloblastoma, astrocytoma and glioma.
 - n. *BMT* for Fanconi's anemia.
 - o. *BMT* for malignant histiocytic disorders.
 - p. *BMT* for juvenile.

Bone marrow transplants when the particular use of the bone marrow transplant procedure is determined to be accepted within the appropriate oncological specialty and not Experimental in accordance with applicable Florida law. As used in this *contract*, the term "bone marrow transplant" means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or nonablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes both the transplantation and the chemotherapy.

Loss means an event for which benefits are payable under this *contract*. A *loss* must occur while the *member* is covered under this *contract*.

Loss of minimum essential coverage means in the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
3. In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
4. A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits;
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 54.9802-1(d)) that includes the individual.
6. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent; and
7. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

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 is the sum of the deductible amount, *prescription drug deductible amount* (if applicable), *copayment amount* and *coinsurance percentage of covered expenses*, as shown in the Schedule of Benefits. After the *maximum out-of-pocket amount* is met for an individual, Ambetter from Sunshine Health pays 100% of *eligible service expenses* for that individual. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' *eligible service expense*. A covered person's maximum out-of-pocket will not exceed the individual maximum out-of-pocket amount.

The Dental out-of-pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum per calendar year as shown in the Schedule of Benefits.

Maximum therapeutic benefit means the point in the course of treatment where no further improvement in a covered person'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 the physicians, physician's assistants, nurses, nurse clinicians, nurse practitioners, pharmacists, marriage and family therapists, clinical social workers, mental health counselors, speech-language pathologists, audiologists, occupational therapists, respiratory therapists, physical therapists, ambulance services, hospitals, skilled nursing facilities, or other health care providers properly licensed in the State of Florida.

Medically necessary means any medical service, supply or treatment authorized by a *physician* to diagnose and treat a *member's illness or injury* which:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Demonstrates that the member is improving in his/her functional ability;
5. Is not solely for the convenience of the *physician* or the *member*;
6. Is not *experimental or investigational*;
7. Is provided in the most cost effective care facility or setting;
8. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; and
9. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of *your* medical symptoms or conditions cannot be safely provided as an outpatient.

Charges incurred for treatment not *medically necessary* are not *eligible service expenses*.

Medically stabilized means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* 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*.

Medicare opt-out practitioner means a *medical practitioner* who:

1. Has filed an affidavit with the Department of Health and Human Services stating that he or she will not submit any claims to Medicare during a two-year period;
2. Has been designated by the Secretary of that Department as a *Medicare opt-out practitioner*.

Medicare participating practitioner means a *medical practitioner* who is eligible to receive reimbursement from Medicare for treating Medicare-eligible individuals.

Member or Covered Person means an individual covered by the health plan including an enrollee, subscriber or policy holder.

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Necessary medical supplies means 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 *physicians* and providers who have contracts that include an agreed upon price for health care services or expenses.

Network eligible service expense means the *eligible service expense* for services or supplies that are provided by a *network provider*. For facility services, this is the *eligible service expense* that is provided at and billed by a *network facility* for the services of either a *network* or *non-network provider*. *Network eligible service expense* includes benefits for *emergency* health services even if provided by a *non-network provider*.

Network provider means a *physician* or provider who is identified in the most current list for the *network* shown on *your* identification card.

Non-network provider means a *physician* or provider who is NOT identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are not covered, except as specifically stated in this policy.

Other plan means any plan or policy that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance organization subscriber contracts, self-insured group plans, prepayment plans, and Medicare when the *member* is enrolled in Medicare. *Other plan* will not include Medicaid.

Out-of-pocket service expenses means those expenses that a *member* is required to pay that:

1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any *other plan*.

Outpatient surgical facility means any facility with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *physician* offices.

Period of extended loss means a period of consecutive days:

1. Beginning with the first day on which a *member* is a *hospital inpatient*; and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient*.

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 his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law which includes chiropractors, podiatrists, and osteopaths. A *physician* does **NOT** include someone who is related to a covered person by blood, marriage or adoption or who is normally a member of the covered person's household.

Post-service claim means any claim for benefits for medical care or treatment that is not a *pre-service claim*.

Pre-service claim means any claim for benefits for medical care or treatment that requires the approval of the plan in advance of the claimant obtaining the medical care.

Pregnancy means the physical condition of being pregnant, but does not include *complications of pregnancy*.

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

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. The family *prescription drug deductible amount* is two times the individual *prescription drug deductible amount*. For family coverage, once a covered person 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 covered persons' *eligible service expenses*.

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, internist, obstetrician or gynecologist.

Proof of loss means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, and *network* re-pricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

Qualified health plan or **QHP** means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Health Insurance Marketplace through which such plan is offered in accordance with the process described in subpart K of part 155.

Qualified individual means, with respect to a Health Insurance Marketplace, an individual who has been determined eligible to enroll through the Health Insurance Marketplace 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.

Reformation of a policy means a determination by an insurer to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by the insurer to all similar individual policy forms is not a *reformation* of a policy.

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and *pain management programs*. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment under a *pain management program*.

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that:

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

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 incompetent.

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

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

Rescission of a policy means a determination by an insurer 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 skilled nursing.

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.

Specialist physician means a *physician* who is not a *primary care physician*.

Spouse means *your* lawful wife or husband.

Sub-acute rehabilitation means one or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for one-half hour to two hours per day, five to seven days per week, while the covered person is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *extended care facility*.

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

Surgery or **surgical procedure** means:

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

Surveillance tests for ovarian cancer means annual screening using:

1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound; or
3. Pelvic examination.

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.

Third party means a person or other entity that is or may be obligated or liable to the *member* for payment of any of the *member's* expenses for *illness* or *injury*. The term "*third party*" includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term "*third party*" will not include any insurance company with a policy under which the *member* is entitled to benefits as a named insured person or an insured *dependent member* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

Tobacco use or use of tobacco means use of tobacco by individuals who may legally use tobacco under federal and state law on average four or more times per week and within no longer than the six months immediately preceding the date application for this *contract* was completed by the *member*, including all tobacco products but excluding religious and ceremonial uses of tobacco.

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

1. "*Well-conducted randomized controlled trials*" means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.
2. "*Well-conducted cohort studies*" means patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

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

DEPENDENT MEMBER COVERAGE

Dependent Member Eligibility

Your *dependent members* become eligible for coverage under this *contract* on the latter of:

1. The date *you* became covered under this *contract*; or
2. The date of a newborn's birth; or
3. 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.

Effective Date for Initial Dependent Members

The *effective date* for your initial *dependent members*, if any, is shown on the Schedule of Benefits. Only *dependent members* included in the application for this *policy* will be covered on your *effective date*.

Coverage for a Newborn Child

All health coverage applicable for children under this *contract* will be provided for a newborn child of a *member* or to a *member's* covered family member from the moment of birth if the newborn is enrolled timely as specified in the Special Enrollment provision.

The coverage, benefits or services for newborns shall consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or pre-maturity and up to \$1,000 transportation costs of the newborn to and from the nearest appropriate facility staffed and equipped to treat the newborn's condition when such transportation is certified by the treating provider as necessary to protect the health and safety of the newborn child.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to *us* by the Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for 31 days from the birth of the child. If notice is not given within the 31 days from birth, *we* will charge an additional premium from the date of birth. If notice is given by the Marketplace within 60 days of the birth of the child, the *contract* 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 for An Adopted Child

Coverage for children under this *contract* will be provided for the adopted child of a *member* who has family coverage in force. Coverage is provided to a child the *member* proposes to adopt who is placed in the *member's* residence in compliance with chapter 63, from the moment of placement. A newborn infant who is adopted by the *member* is covered from the moment of birth if a written agreement to adopt such child has been entered into prior to the birth of the child, whether or not such agreement is enforceable. However, coverage will not be provided in the event the child is not ultimately placed in the *member's* residence in compliance with chapter 63, Florida Statutes.

The *member's* adopted child is covered from the moment of placement in the residence, or if a newborn, from the moment of birth, if the child is enrolled timely as specified in the Special Enrollment Period provision.

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and where the issuer is notified by the Marketplace. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both: (A) Notification of the addition of the child from the Marketplace

within 60 days of the birth or placement and (B) any additional premium required for the addition of the child within 90 days of the date of *placement*

As used in this provision, "*placement*" means the earlier of:

1. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption;
or
2. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

Adding Other Dependent Members

If *you* apply in writing for coverage on a *dependent member* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent member* is covered.

ONGOING ELIGIBILITY

For All Members

A *member's* eligibility for coverage under this *contract* will cease on the earlier of:

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*;
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes;
3. The primary *member* residing outside the service area or moving permanently outside the service area of this plan.

For Dependent Members

A *dependent member* will cease to be a *member* at the end of the premium period in which he or she ceases to be *your dependent member* due to divorce or if a child ceases to be an *eligible child*.

We must receive notification within 90 days of the date a *dependent member* ceases to be an eligible *dependent member*. If notice is received by us more than 90 days from this date, any unearned premium will be credited only from the first day of the *policy*/calendar month in which we receive the notice.

A *member* will not cease to be a *dependent eligible child* solely because of age if the *eligible child* is:

1. Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and
2. Mainly dependent on *you* for support.

If health benefits are denied for the stated reason that the child has reached the limiting age for dependent coverage specified in this *contract*, the *member* has the burden of establishing that the child continues to meet the criteria specified above. Failure to provide the required proof may result in the dependent's termination of coverage.

The coverage of the handicapped child may be continued, but not beyond the termination date of such incapacity or such dependence. This provision shall in no event limit the application of any other *contract* provisions terminating such child's coverage for any other reason than the attainment of the limiting age.

Open Enrollment

There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 1, 2015 and extends through January 31, 2016. *Qualified individuals* who enroll prior to December 15, 2015 will have an *effective date* of coverage on January 1, 2016. *Qualified individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month between December 2015 and January 31, 2016, will have a coverage *effective date* of the first day of the second following month.

The Health Insurance Marketplace may provide a coverage *effective date* for a *qualified individual* earlier than specified in the paragraphs above, provided that either:

1. The *qualified individual* has not been determined eligible for *advance premium tax credits* or *cost-sharing reductions*; or
2. The *qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2014, we will send written annual

open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special and Limited Enrollment

A *qualified individual* has 60 days to report a qualifying event to the Exchange and could be granted a 60 day Special Enrollment Period as a result of one of the following events:

1. A *qualified individual* or *dependent* loses *minimum essential coverage*;
2. A *qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption or placement for adoption;
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. A *qualified individual's* enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
5. An enrollee adequately demonstrates to the Health Insurance Marketplace that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
6. An individual is determined newly eligible or newly ineligible for *advance payments of the premium tax credit* or has a change in eligibility for *cost-sharing reductions*, regardless of whether such individual is already enrolled in a *qualified health plan*;
7. A *qualified individual* or enrollee gains access to new *qualified health plans* as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. 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; or
10. A *qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide. *Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance premium tax credits* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where *qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

PREMIUMS

Premium Payment

Each premium is to be paid to *us* on or before its due date. The initial premium must be paid prior to the coverage *effective date*.

Grace Period

When a member is receiving a premium subsidy:

After the first premium is paid, a grace period of three (3) months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if advance premium tax credits are received.

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. *We* will notify HHS of the non-payment of premiums, 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. A member is not eligible to re-enroll once terminated, unless a member has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

When a member is not receiving a premium subsidy:

Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a one (1) month grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *Contract* will stay in force. *We* will notify HHS, 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.

Misstatement of Age

If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change or Misstatement of Residence

If *you* change *your residence*, *you* must notify the Exchange of *your new residence* within 60 days of the change. As a result your premium may change and you may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

Misstatement of Tobacco Use

The answer to the tobacco question on the application is material to *our* correct underwriting. If a *member's use of tobacco* has been misstated on the *member's* application for coverage under this *contract*, *we* have the right to rerate the *contract* back to the original *effective date*.

Billing/Administrative Fees

Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a \$20 fee for any check or automatic payment deduction that is returned unpaid.

MAJOR MEDICAL EXPENSE BENEFITS

Deductible

The *deductible amount* means the amount of *covered service expenses* that must be paid by each/all *members* before any benefits are provided or payable. The *deductible amount* does not include any *copayment amount*.

Cost Sharing Percentage

We will pay the applicable *cost sharing percentage* in excess of the applicable *deductible amount(s)* and *copayment amount(s)* for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *member's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible service expense*.

When the annual out-of-pocket maximum has been met, additional *covered service expenses* will be provided or payable at 100%.

Refer to your Schedule of Benefits for Coinsurance Percentage and other limitations.

The amount provided or payable will be subject to:

1. Any specific benefit limits stated in the *contract*; and
2. A determination of *eligible service expenses*.

The applicable *deductible amount(s)*, *cost sharing percentage*, and *copayment amounts* are shown on the Schedule of Benefits.

Note: The bill *you* receive for services or supplies from a non-*network provider* may be significantly higher than the *eligible service expenses* for those services or supplies. In addition to the *deductible amount*, *copayment amount*, and *cost sharing percentage*, *you* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or out-of-pocket maximum.

Primary Care Physician

In order to obtain benefits, *you* may be required to designate a *network primary care physician* for each *member*. *You* may select any *network primary care physician* who is accepting new patients. However, *you* may not change your selection more frequently than once each month. If *you* do not select a *network primary care physician* for each *member*, one will be assigned. *You* may obtain a list of *network primary care physicians* at our website or by contacting our Member Services Department.

Your network primary care physician will be responsible for coordinating all covered health services and making referrals for services from other *network providers*. *You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment and may seek care directly from a *network obstetrician* or gynecologist.

You may change *your network primary care physician* by submitting a written request, online at our website, or by contacting our office at the number shown on *your* member ID. The change to *your network primary care physician* of record will be effective no later than 30 days from the date we receive *your* request.

Referral Required For Maximum Benefits

You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network obstetrician or gynecologist*. For all other *network specialist physicians*, you may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy* or benefits payable under this *contract* may be reduced. Please refer to the Schedule of Benefits.

Network Availability

Your network is subject to change upon advance written notice. A *network* may not be available in all areas. If you move to an area where we are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. You will be notified of any increase in premium.

Coverage Under Other Policy Provisions

Charges for services and supplies that qualify as *covered service expenses* under one benefit provision will not qualify as *covered service expenses* under any other benefit provision of this *contract*.

Ambulance Service Benefits

Covered service expenses will include ambulance services for local transportation:

1. To the nearest *hospital* that can provide services appropriate to the *member's illness or injury*.
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 when approved by Ambetter from Sunshine Health.

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. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-*emergency* air ambulance.
3. Non-*emergency* ground transportation.
4. Air ambulance:
 - 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.
5. Ambulance services provided for a *member's* comfort or convenience.

Mental Health and Substance Use Disorder Benefits

Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter from Sunshine Health. If you need mental health and/or substance use disorder treatment, you may choose any provider participating in Cenpatico's provider network and do not need a referral from your *primary care physician* in order to initiate treatment. Deductibles, 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 and substance use disorder are included on a non-discriminatory basis for all Members for the diagnosis and *medically necessary* and active treatment of mental, emotional, and/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. Diagnoses known as “V Codes” are *eligible service expenses* only when billed as a supporting diagnosis.

When making coverage determinations, Cenpatico 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. Cenpatico utilizes “Interqual” criteria for mental health determinations and “ASAM” criteria for substance abuse 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.

Covered Inpatient, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient

1. Inpatient treatment;
2. Observation;
3. Crisis Stabilization; and
4. Electroconvulsive Therapy (ECT).

Intermediate

1. Partial Hospitalization Program (PHP) for Mental Health;

Outpatient

1. Traditional outpatient services, including individual and group therapy services;
2. Medication management services;
3. Diagnostic testing;
4. Biofeedback; and
5. Psychological testing.

Expenses for these services are covered, if *medically necessary* and may be subject to prior authorization. Please see the Schedule of Benefits for more information regarding services that require prior authorization and specific benefit, day or visit limits, if any.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
 - a. Daily room and board and nursing services.

- b. Diagnostic testing.
- c. Drugs and medicines prescribed by a *physician*, filled by a licensed pharmacist and approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-provider facility services are limited to charges incurred for the professional services of *rehabilitation medical practitioners*.

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

Care ceases to be *rehabilitation* 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*.

Exclusion:

No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Home Health Care Service Expense Benefits

Covered service expenses for *home health care* are limited to the following charges:

1. *Home health aide services*.
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care*.
3. I.V. medication and pain medication.
4. Hemodialysis, and for the processing and administration of blood or blood components.
5. *Necessary medical supplies*.
6. Rental of *medically necessary durable medical equipment*.
 - a.

Charges under (4) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital stay*.

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 that *we* authorize before the purchase.

Limitations:

See the Schedule of Benefits for benefit levels or additional limits for expenses related to home health aide services.

Exclusion:

No benefits will be payable for charges related to *respite care*, *custodial care*, or educational care.

Hospice Care Service Expense Benefits

This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice care program*.

The list of *covered service expenses* in the Miscellaneous Medical Service Expense Benefits provision is expanded to 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* covered person 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 his or her *terminal illness*.
7. *Terminal illness counseling* of the *member's immediate family*.
8. *Bereavement counseling*, refer to your Schedule of Benefits.

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill* covered person.

Refer to your Schedule of Benefits for daily and lifetime limits.

Respite Care Expense Benefits

Respite care is covered on an outpatient basis to allow temporary relief to family members from the duties of caring for a Covered Person. Respite days that are applied toward the Deductible are considered benefits provided and shall apply against any Maximum Benefit limit for these services. See your Schedule of Benefits for lifetime limits.

Medical Foods

We cover medical foods and formulas for outpatient total parenteral therapy; outpatient elemental formulas for malabsorption; and dietary formula when *medically necessary* for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism.

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

Second Medical Opinion

Members are entitled to a second medical opinion under the following conditions:

1. Whenever a minor surgical procedure is recommended to confirm the need for the procedure;
2. Whenever a serious injury or illness exists; or
3. Whenever *you* find that *you* are not responding to the current treatment plan in a satisfactory manner.

If requested, the second opinion consultation is to be provided by a *physician* of the *member's* choice. The *member* may select a *network provider* listed in the Ambetter from Sunshine Health Provider Directory or a *non-network provider* located in the Ambetter from Sunshine Health service area. If a *member* chooses a *network provider*, he or she will only be responsible for the applicable co-payment for the consultation. If a *member* chooses a *non-network provider*, Ambetter from Sunshine Health will pay 60% of the usual and customary charge for the second opinion. At the time of service, the *member* must pay the *non-network provider* the entire charges incurred for the second opinion and submit a claim for reimbursement. Ambetter from Sunshine Health will reimburse the *member* the usual and customary amount for the second opinion consultation less 40% of such amount.

If a *member* would like a second medical opinion, the *member* must first notify his or her *primary care*

physician who will initiate a request for consultation. Any covered diagnostic tests requested by the *physician* providing the second opinion must be coordinated by the *member's primary care physician*, and if *medically necessary*, performed by an Ambetter from Sunshine Health *physician*. Any lab tests and/or diagnostic and therapeutic services are subject to the additional co-payment.

The *physician* providing the second opinion will provide the *member's primary care physician* with a written opinion. Please note that the *physician* who provides the second opinion will not perform the surgery or initiate any treatment to correct the condition for which the original recommendation was given, unless authorized by the *member's primary care physician*.

Miscellaneous Medical and Surgical Expense Benefits

Medical covered service expenses are limited to charges:

1. Made by a *hospital* for:
 - a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
 - b. Daily room and board and nursing services while confined in an *intensive care unit*.
 - c. *Inpatient* use of an operating, treatment, or recovery room.
 - d. Outpatient use of an operating, treatment, or recovery room for *surgery*.
 - e. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* to persons for use only while they are *inpatients*.
 - f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your Schedule of Benefits for limitations.
2. For *surgery* in a *physician's* office or at an *outpatient surgical facility*, including services and supplies.
3. Made by a *physician* for professional services, including *surgery*.
4. Made by an assistant surgeon. See your Schedule of Benefits for eligible limits.
5. For the professional services of a *medical practitioner*.
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies*.
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
8. For chemotherapy and radiation therapy or treatment.
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
10. For the cost and administration of an anesthetic.
11. For dental treatment in a Hospital or Ambulatory Surgical Center. Benefits are available for general anesthesia and hospitalization services in connection with necessary dental treatment or surgery, subject to prior authorization by us.
 1. A *member* under age eight (8) whose treating Health Care Professional, in consultation with the dentist, determines the child has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
 2. A *member* who has one (1) or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.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 by us. Please call Member Services to confirm *your* benefits for the use of general anesthesia in a Hospital or Ambulatory Surgical Center.
12. For oxygen and its administration.
13. For dental service expenses when a member suffers an injury, after the member's effective date of coverage, that results in:
 - a. Damage to his or her natural teeth; and

- b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.
14. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint. See the Schedule of Benefits for benefit levels or additional limits.
15. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas. Coverage for outpatient post-surgical care is provided in the most medically appropriate setting which may include a hospital, treating *physician's* office, outpatient center or the *member's* home. Inpatient hospital treatment for mastectomy will not be limited to any period that is less than that recommended by the attending physician.
16. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract*, including *deductible amount* and *cost sharing percentage* provisions.
17. For a female *member*. *Covered service expenses* are permitted when a female *member* receives services from a *network provider* specializing in obstetrics and gynecology for obstetrical or gynecological care or if medically necessary follow-up care is detected at the visit without a referral from her *primary care physician*.
18. For the following types of tissue transplants:
 - a. Cornea transplants;
 - b. Artery or vein grafts;
 - c. Heart valve grafts;
 - d. Prosthetic tissue replacement, including joint replacements; and
 - e. Implantable prosthetic lenses, in connection with cataracts.
19. Family Planning for certain professional provider contraceptive services and supplies, including but not limited to sterilization and vasectomies, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.
20. Cochlear implants.
21. *Covered services* for *medically necessary* diagnosis and treatment of osteoporosis for high-risk *member*, including, but not limited to, estrogen-deficient *members* who are at clinical risk for osteoporosis, *members* who have vertebral abnormalities, individuals who are receiving long-term hyperparathyroidism and *members* who have a family history of osteoporosis.
22. Cleft lip and cleft palate for an *eligible child* under the age of 18. *Covered services* includes 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.
23. 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*. See the Schedule of Benefits for benefit levels or additional limits.
24. Mammograms as follows: (a) A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age; (b) A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's physician's recommendations; (c) A mammogram every year for any woman who is 50 years of age or older; (d) One or more mammograms a year, based upon a physician's recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer,

because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of 30. This benefit is not subject to deductibles or copayments.

Diabetic Care

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

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits

Covered expenses for miscellaneous outpatient medical services and supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the covered person and the item cannot be modified). If more than one prosthetic device can meet a covered person's functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered expense*.
2. For one pair of foot orthotics per year per covered person.
3. For *medically necessary* genetic blood tests.
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
5. For two mastectomy bras per year if the covered person has undergone a covered mastectomy.
6. For rental of *medically necessary* durable medical equipment.
7. For the rental of one Continuous Passive Motion (CPM) machine per covered person following a covered joint surgery.
8. For the cost of one wig per covered person necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.
9. For one pair of eyeglasses or contact lenses per covered person following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.

Outpatient Prescription Drug Expense Benefits

Covered service expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:

1. A *prescription drug*.
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription by a *physician*.

See the Preferred Drug List and Schedule of Benefits for additional information on drug coverage, benefit levels or additional limits.

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *physician*.

Notice and Proof of Loss:

In order to obtain payment for *covered service expenses* incurred at a *pharmacy* for *prescription orders*, a notice of claim and *proof of loss* must be submitted directly to us.

Non-Covered Services and Exclusions:

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

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance.
2. For immunization agents, blood, or blood plasma, except when used for preventative care.
3. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
4. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
5. For a refill dispensed more than 12 months from the date of a *physician's* order.
6. Due to a *member's* addiction to, or dependency on foods.
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 covered on the formulary or when the over-the-counter drug is used for preventative care.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For a *prescription drug* that contains (an) active ingredient(s) that is/are:
 - a. Available in and *therapeutically equivalent* to another covered *prescription drug*; or
 - b. A modified version of and *therapeutically equivalent* to another covered *prescription drug*.
Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by 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.

Pediatric Vision Expense Benefits

Covered service expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *member*:

1. Routine vision screening, including dilation and with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of standard contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of frames every calendar year;
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:

1. Visual therapy
2. Two pair of glasses as a substitute for bifocals
3. Replacement of lost or stolen eyewear
4. Any vision services, treatment or material not specifically listed as a *covered service*; or
5. Out of network care except when pre-authorized.

Preventive Care Expense Benefits

Covered service expenses are expanded to include the charges incurred by a *member* for the following preventive health services if appropriate for that *member* in accordance with the following recommendations and guidelines:

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual which includes pediatric and adult immunizations.
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration which includes well-child care from birth.
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
5. Covers without cost sharing:
 - a. Screening for *tobacco use*; and
 - b. For those who *use tobacco* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
 - i. Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
 - ii. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.
6. Eye screenings by a licensed physician or optometrist and ear screenings by a physician for children through age 17, to determine the need for vision and hearing correction.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any *deductibles*, *cost sharing percentage* provisions, and *copayment amounts* under the *contract* when the services are provided by a *network provider*.

Benefits for *covered expenses* 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 services from *network providers*. Reasonable medical management techniques may result in the application of deductibles, coinsurance provisions, or *copayment amounts* to services when a covered person 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*.

As new recommendations and guidelines are issued, those services will be considered *covered service expenses* when required by the United States Secretary of Health and Human Services, but not earlier than one year after the recommendation or guideline is issued.

Child Health Supervision Services

The following *covered service* is provided for an *eligible child* in accordance with the Florida Child Health Assurance Act which includes *covered services* from the moment of birth to age 16 years. A waiver of the *deductible amount* applies to all *eligible service expenses* for Child Health Supervision Services.

Child Health Supervision Services means *physician-delivered* or *physician-supervised* services that include the services described in the Schedule of Benefits. These services do not include *hospital charges*.

Child Health Supervision Services include periodic visits, which shall include:

- History
- Physical Examination
- Developmental Assessment
- Anticipatory Guidance
- Appropriate Immunizations
- Laboratory Testing

These services and periodic visits will be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

Eligible service expenses for child health supervision services are limited to one visit payable to one provider for all the services provided at each visit.

Newborns' and Mothers' Health Protection Act Statement of Rights

If services provided or expenses incurred for *hospital* confinement in connection with childbirth are otherwise included as *covered Service expenses*, we will not limit the number of days for these expenses to less than that stated in this provision.

Maternity care

Coverage for outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, services of nurse-midwives and midwives licensed according to Florida law, and the services of birth centers licensed according to Florida law, if such services are available within the service area, and hospital stays for delivery or other *medically necessary* reasons (less any applicable *copayments, deductible amounts, or cost sharing percentage*). Other maternity benefits include *complications of pregnancy*, parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests. Coverage will only be provided for maternity services and/or care of the newborn child when such services have been authorized by your participating health care provider.

Under federal law, health insurance issuers generally may not restrict benefits otherwise 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* may provide benefits for *covered service expenses* 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 (or 96-hour) stay 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 (or 96 hours).

Note: This provision does not amend the *contract* to restrict any terms, limits, or conditions that may otherwise apply to *covered service expenses* for childbirth.

Clinical Trial Coverage

Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition . Coverage will include routine patient care costs incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, (2) reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

- The investigational item or service itself;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Phase I and II clinical trials must meet the following requirements:

- Phase I and II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and
- The insured is enrolled in the clinical trial. This section shall not apply to insureds who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

Phase III and IV clinical trials must be approved or funded by one of the following entities:

- One of the National Institutes of Health (NIH);
- The Centers for Disease Control and Prevention;
- The Agency for Health Care Research and Quality;
- The Centers for Medicare & Medicaid Services;
- An NIH Cooperative Group or Center;
- The FDA in the form of an investigational new drug application;
- The federal Departments of Veterans' Affairs, Defense, or Energy;
- An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; or
- A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

In a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, noninvestigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the noninvestigational alternatives.

Providers participating in clinical trials shall obtain a patient's informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:

If we determine that a *member* is an appropriate candidate for a *listed transplant*, Medical Service Expense Benefits will be provided for:

1. Pre-transplant evaluation;
2. Pre-transplant harvesting;
3. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *member* to prepare for a later transplant, whether or not the transplant occurs;
4. High dose chemotherapy;
5. Peripheral stem cell collection;
6. The transplant itself, not including the acquisition cost for the organ or bone marrow (except at a *Center of Excellence*); and
7. Post transplant follow-up.

Transplant Donor Expenses:

We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *member* if:

1. They would otherwise be considered *covered service expenses* under the *contract*;
2. The *member* received an organ or bone marrow of the live donor; and
3. The transplant was a *listed transplant*.

Ancillary "Center Of Excellence" Service Benefits:

A *member* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence*:

1. *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.
2. We will pay a maximum amount shown in the Schedule of Benefits for the following services:
 - a. Transportation for the *member*, any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence*.
 - b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence*. We will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Non-Covered Services and Exclusions:

No benefits will be provided or paid under these Transplant Expense Benefits:

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
3. For animal to human transplants.
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *listed transplant*.
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("*FDA*") regulation, regardless of whether the trial is subject to *FDA* oversight. Note: This exclusion does not apply to bone marrow transplants.

Limitations on Transplant Service Expense Benefits:

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

1. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *member* with the exception of *Bone Marrow Transplants* which will be covered when *medically necessary*.
2. Bone marrow transplant coverage for the reasonable costs of searching for a donor will be limited to a search among family members and donors identified through the National Bone Marrow Donor Program.
3. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
4. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Wellness Program Benefits

Benefits may be available from time to time to *members* for participating in certain wellness programs that *we* may make available in connection with this *contract*. The benefits available to *members* for participating in the wellness programs are described on the Schedule of Benefits. You may obtain information regarding the particular wellness programs available at any given time by visiting *our* website at <http://ambetter.sunshinehealth.com/> or by contacting Member Services by telephone at 1- 877-687-1169. The wellness programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change from time to time by *us* through an update to wellness program information available on *our* website or by contacting *us*

PRIOR AUTHORIZATION

Prior Authorization Required

Some *covered service expenses* require prior authorization. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *member*. However, there are some *network eligible service expenses* for which *you* 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 the *member*:

1. Receives a service or supply from a non-*network provider*;
2. Is admitted into a *network* facility by a non-*network provider*; or
3. Receives a service or supply from a *network provider* to which the *member* was referred by a non-*network provider*.

How to Obtain Prior Authorization

To obtain prior authorization or to confirm that a *network provider* has obtained prior authorization, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *member*.

Failure to Obtain Prior Authorization

Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.

Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency*. However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior Authorization Does Not Guarantee Benefits

Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *contract*.

Requests for Predeterminations

You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us*.
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

We will make all benefit determinations after a *loss* in good faith. All benefit determinations are subject to *our* receipt of proper *proof of loss*.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

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/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 by a member of a *member's immediate family*.
4. Any services not identified and included as *covered service expenses* under the *contract*. You will be fully responsible for payment for any services that are not *covered service expenses*.
5. Court ordered care- unless medically necessary.

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*; and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness*, or covered under the Preventive Care Expense Benefits provision.

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, except as expressly provided for under the Benefits After Coverage Terminates clause in this *policy's* Termination section.
2. For any portion of the charges that are in excess of the *eligible service expense*.
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *member*, such as sex-change *surgery*.
6. For reversal of sterilization and reversal of vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
8. For expenses for television, telephone, or expenses for other persons.
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
10. For telephone consultations or for failure to keep a scheduled appointment.
11. For stand-by availability of a *medical practitioner* when no treatment is rendered.
12. For *dental service expenses*, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Service Expense Benefits.
13. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
14. For diagnosis or treatment of learning disabilities.
15. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
16. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
17. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
18. While confined primarily to receive *rehabilitation*, *custodial care*, educational care, or nursing services (unless expressly provided for in this *contract*).

19. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
20. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine.
21. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
22. For *experimental or investigational treatment(s) or unproven services*. The fact that an *experimental or investigational treatment or unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment or unproven service* for the treatment of that particular condition.
23. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of 90 consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
24. 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.
25. As a result of:
 - a. Intentionally self-inflicted bodily harm.
 - b. The *member* taking part in a riot.
 - c. The *member's* commission of a felony, whether or not charged.
26. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
27. For any *illness or injury* incurred as a result of the *member* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*, except as expressly provided for under the Mental Health and Substance Use Disorder Benefits provision.
28. For or related to surrogate parenting.
29. For or related to treatment of hyperhidrosis (excessive sweating).
30. For fetal reduction surgery.
31. Except as specifically identified as a *covered service expense* under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
32. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or Semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).
33. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or

receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.

34. As a result of any *injury* sustained while at a *residential treatment facility*.
35. 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.
36. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); biofeedback; blood and blood products; care or complications resulting from non-covered services; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-member biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;

Limitations on Benefits for Services Provided By Medicare Opt-Out Practitioners

Benefits for *covered service expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.)

PLAN ADMINISTRATION

In consideration of the payment of premium by the *member*, we will provide coverage for the *member* and their *eligible dependents*. In doing so, we may enter into agreements with providers of health care and such other individuals and entities as may be necessary to enable us to fulfill its obligations under this *contract*.

We agree to provide coverage without discrimination because of race, color, national origin, disability, sex, gender identity, sexual orientation, religion, or any other basis prohibited by law.

Commencement of Coverage

Commencing on the *contract effective date* we agree to provide the coverage stipulated in this *contract* to the *member* and his/her *dependents*, if any. Such coverage begins on the *member's* effective date, which will be the first of the month after the receipt and approval of the application by us, unless this *contract* specifies a date other than the first of the month. We accept no liability for benefits related to expenses incurred prior to *your* effective date or after *your* termination date, which will be on the last day of the coverage month, except or as specified in the Terms of Renewal provision.

Plan Renewal

This *contract* is guaranteed renewable. Coverage under this *contract* is for an initial term of twelve (12) months commencing as of the *effective date* of the *member's* coverage and will automatically renew for successive terms of twelve (12) months unless terminated or non-renewed as provided for in this *contract*. Rate changes are effective on a *member's* annual renewal date and will be based on each *member's* attained age, family structure, geographic region, tobacco usage and benefit plan at the time of renewal. We will notify the *member* in writing at least thirty (30) days prior to the renewal date of any change in premium rates.

For *members* who have elected the electronic funds transfer option of payment, should premiums change at renewal, we will continue to draft the new monthly premium.

Term of Renewal

We guarantee the *member* the right to renew the Plan each year, at the *member's* option. However, we may refuse to renew this Plan, and all coverage provided under this Plan, if one of the following circumstances has occurred:

1. Failure to timely pay premium in accordance with the terms of the Plan;
2. We cease offering this Plan to all *members*;
3. The *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Plan;
4. The *member* no longer lives in *our* geographic Service Area;
5. We elect to discontinue all individual health coverage in the State of Florida; and
6. We elect to discontinue offering individual health coverage through the Health Insurance Marketplace.

With the exception of non-payment of premium or loss of eligibility, if we decides to terminate or non-renew this Plan for any of the reasons set forth in this Plan, we will give the *member* at least forty-five (45) days advance written notice prior to renewal. If we discontinue offering all individual coverage in Florida, we will give all *members* and the Office of Insurance Regulation 180 day's written notice prior to the Plan non- renewal date.

Termination of This Plan by the Member

The *member* may terminate this Plan at any time with appropriate notice of at least fourteen (14) days to either *us* or the Health Insurance Marketplace. Coverage will terminate on the date specified by the *member*, or fourteen (14) days after termination is requested, whichever is later. If the *Member* requests termination in fewer than fourteen (14) days, and *we* can effectuate this request in a shorter period of time, then coverage will terminate on the date determined by *us*. No benefits will be provided as of the effective date of termination of this Plan for whatever reason.

Should the *member* and/or any covered dependents terminate coverage because of eligibility for Medicaid, CHIP or a Basic Health Plan or termination is due to the *member* moving from one *qualified health plan* to another during an Annual or Special Enrollment Period, the termination effective date will be the day before the effective date of the new coverage.

Discontinuance of a Benefit Plan

We may discontinue offering a particular benefit plan to all *members* if:

1. *We* provide at least ninety (90) days notice to each *member* prior to the plan renewal date; and
2. *We* offer each *member* the option to purchase any other coverage offered in the individual HMO market, and
3. *We* act uniformly without regard to any health status-related factor of each *member*.

Discontinuance of All Coverage in the Individual Market

We may discontinue offering all coverage in Florida if:

1. *We* provide notice to the Office of Insurance Regulation and each *member* and enrollee 180 days prior to renewal; and
2. All health coverage issued or delivered for issuance in Florida is discontinued and coverage under such health coverage is not renewed.

Termination of this Plan by Us

Except for nonpayment of premium or termination of eligibility, *we* may not cancel or terminate or non-renew this *contract* without giving the *member* at least forty-five (45) days written notice. The written notice will state the reason or reasons for the cancellation, termination or non-renewal.

We may terminate this *contract* as of any premium due date if the *member* has not paid the required premium by the end of the Grace Period, as defined in the Grace Period provision. The *member* is liable to *us* for any unpaid premium for the time the Plan was in force.

Upon termination of coverage, *we* will have no further liability for the payment of any covered services provided after the date of the *Member's* termination.

Plan Termination Due to Non-Payment of Premium

If the *member* is receiving premium subsidies, the following provision applies:

- If the required monthly premium is not received by the end of the ninety (90) day Grace Period, *we* will terminate coverage effective at midnight on the last day of the first month of the three (3) month grace period.

If the *member* is not receiving premium subsidies, the following provision applies:

- If the required monthly premium is not received by the end of the ten (10) day grace period, *we* will terminate this *contract*, without prior notification, retroactive to the last date for which

premium was received, subject to the Grace Period provision. Termination will be effective as of midnight of the date that the premium was due provided we mail written notice of termination to the *member* prior to forty-five (45) days after the date the premium was due.

Termination of Coverage by the Health Insurance Marketplace or Us

The Health Insurance Marketplace may terminate coverage in a qualified health plan and will also permit us to terminate coverage for any of the following reasons:

1. Loss of eligibility to purchase a qualified health plan through the Health Insurance Marketplace.
2. Nonpayment of premiums provided that the grace period has elapsed.
3. Coverage is rescinded.
4. We terminate or are decertified by the Health Insurance Marketplace.
5. An enrollee switches to another qualified health plan during an Annual Open Enrollment Period or a Special Enrollment Period.

Terms of Renewal

We guarantee the *member* the right to renew the Plan each year, at the *member's* option. However, we may refuse to renew this Plan, and all coverage provided under this Plan, if one of the following circumstances has occurred:

1. The member fails to timely pay premium in accordance with the terms of the Plan;
2. We cease offering this Plan to all members;
3. The member has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Plan;
4. The member no longer lives or works in our geographic Service Area; and
5. We elect to discontinue all individual health coverage in the State of Florida.

With the exception of non-payment of premium or loss of eligibility, if we decide to terminate or non-renew this Plan for any of the reasons set forth in this Plan, we will give the *member* at least forty-five (45) days advance written notice.

Discontinuance

90-Day Notice: If we discontinue offering and refuse to renew 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 and all enrollees* at least 90 days prior to the date that we discontinue coverage. *You* will be offered an option to purchase any other coverage in the individual market we offer in *your* state at the time of discontinuance of this *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 and refuse to renew all individual contracts in the individual market in the state where *you* reside, we will provide a written notice to *you*, all enrollees, and the Commissioner of Insurance at least 180 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 *dependent member* to notify us within 31 days of *your* legal divorce or *your dependent member's* marriage.

Benefits After Coverage Terminates

If a *network provider* terminates his or her contract with Ambetter from Sunshine Health or is terminated

by Us for any reason other than for cause, a *member* receiving active treatment may continue coverage and care with that *network provider* when *medically necessary* and through completion of treatment of a condition for which the *member* was receiving care at the time of the termination until:

1. The *member* selects another treating provider or during the next open enrollment period, whichever is longer, but not longer than six (6) months after termination of the provider's contracts.
2. The *member* who is pregnant and who has initiated a course of prenatal care regardless of the trimester in which care was initiated, completes postpartum care.

A *network provider* may refuse to continue to provide care to a *member* who is abusive, non-compliant, or in arrears in payment for services provided.

Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries*. However, no benefits are provided if this *contract* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss*, as defined below. The *period of extended loss* must begin before coverage of the *member* ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all contracts issued on this form, with the same type and level of benefits, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *contract*. In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss*, but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

REIMBURSEMENT

If a *member's illness or injury* is caused by the acts or omissions of a *third party*, we will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

However, if payment by or for the *third party* has not been made by the time we receive acceptable *proof of loss*, we will pay regular *contract* benefits for the *member's loss*. We will have the right to be reimbursed, providing it is not in conflict with any applicable Florida Statute or the decisions of courts of competent jurisdiction which eliminate or restrict such rights, to the extent of benefits we provided or paid for the *illness or injury* if the *member* subsequently receives any payment from any *third party*. The *member* (or the guardian, legal representatives, estate, or heirs of the *member*) shall promptly reimburse us from the settlement, judgment, or any payment received from any *third party*.

As a condition for *our* payment, the *member* or anyone acting on his or her behalf (including, but not limited to, the guardian, legal representatives, estate, or heirs) agrees:

1. To fully cooperate with us in order to obtain information about the *loss* and its cause;
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*;
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 all money 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; and
 - e. May assert that subrogation right, providing it is not in conflict with any applicable Florida Statute or the decisions of courts of competent jurisdiction which eliminate or restrict such rights, independently of the *member*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to us any documents we request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing us with written notice of the intent to do so.
8. To reimburse us from any money received from any *third party*, to the extent of benefits we paid for the *illness or injury*, whether obtained by settlement, judgment, or otherwise, and whether 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* has agreed to reimburse us.

Furthermore, as a condition of *our* payment, we may require the *member* or the *member's* guardian (if the *member* is a minor or legally incompetent) to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

We have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

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

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

COORDINATION OF BENEFITS

Ambetter coordinates benefits with other payers when a member is covered by two or more group health benefit plans. Coordination of Benefits (COB) is the industry standard practice used to share the cost of care between two or more carriers when a member is covered by more than one health benefit plan.

It is a contractual provision of a majority of health benefit contracts. Ambetter complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners(NAIC).

Under COB, the benefits of one plan are determined to be primary and are first applied to the cost of care. After considering what has been covered by the primary plan, the secondary plan may cover the cost of care up to the fully allowed expense according to the plan's payment guidelines. Ambetter Claims COB and Recovery Unit procedures are designed to avoid payment in excess of allowable expense while also making sure claims are processed both accurately and timely.

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.
2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
3. Plan includes hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other
4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
5. Plan does not include Individual or Family:
Insurance contracts, direct payment subscriber contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.
6. Plan whose benefits are by law excess to any private benefits coverage.

"Primary plan" is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either:

- (1) The plan has no order of benefits rules or its rules differ from those required by regulation; or (2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

"Secondary plan" is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in

relation to each other.

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. The primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:
 - a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder; and
 - b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

3. If the person receiving benefits is the *member* and is only covered as *an eligible dependent* under the other plan, this *contract* will be primary.
4. Subject to State Statutes: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
 - a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
 - b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
5. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
 - a. The plan of the parent who has custody will be primary;
 - b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
 - c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
6. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
7. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum available benefit for each Covered Service. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Needed Information

Certain fact 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 the person claiming benefits. *We* need not tell or get the consent of, any person to do this.

CLAIMS

Notice of Claim

When a non-participating provider renders services, notice of a claim for benefits must be given to *us*. The notice must be in writing, and any claim will be based on that written notice. The notice must be received by *us* within 20 days after the date of the injury or the first treatment date for the sickness on which the claim is based. If this required notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the 20 day period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

Proof of Loss

You or *your* covered *dependent member* must give *us* written *proof of loss* within 90 days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year late will not be accepted, unless *you* had no legal capacity in that year.

Cooperation Provision

Each *member*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *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 *we* deem relevant from any person or entity.
2. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant.
3. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask.
4. Furnish any other information, aid or assistance that *we* may require, including without limitation, 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 requested by *us*).

If any *member*, or other person acting on his or her 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*.

In addition, failure on the part of any *member*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of the claim at issue to the covered person.

Time for Payment of Claims

Benefits will be paid as soon as *we* receive proper *proof of loss*.

Foreign Claims Incurred for Emergency Care

Claims incurred outside of the United States for *emergency* care and treatment of a *member* must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper *proof of loss*.

Assignment

We will reimburse a *hospital* or health care provider if:

1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

Any assignment to a *hospital* or person providing the treatment, whether with or without *our* approval, shall not confer upon such *hospital* or person, any right or privilege granted to *you* under the *contract* except for the right to receive benefits, if any, that *we* have determined to be due and payable.

Medicaid Reimbursement

The amount provided or payable under this *contract* will not be changed or limited for reason of a *member* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *contract* to the state if:

1. A *member* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

Our payment to the state will be limited to the amount payable under this *contract* for the *covered service expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

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*.

Physical Examination

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

Legal Actions

No suit may be brought by *you* on a claim sooner than 60 days after the required *proof of loss* is given. No suit may be brought more than five years after the date *proof of loss* is required.

Prior to initiating any action at law, *you* are encouraged to first complete all the steps in the complaint/*grievance* procedures made available to resolve disputes in *your* state under the *contract*. After completing that complaint/*grievance* procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within five years of the date *we* notified *you* of the final decision on *your* complaint/*grievance*.

GRIEVANCE AND COMPLAINT PROCEDURES

INTERNAL PROCEDURES:

Applicability/Eligibility

The internal *grievance* procedures apply to any hospital or medical policy or certificate, but not to accident only or disability only insurance.

There are three categories of complaints that Ambetter *members* have a right to file: complaints, grievances and appeals. The process for each is described in this section.

Grievance/Appeal

Ambetter *members* have up to 365 calendar days to file a Grievance. The 365 calendar days start on the date of the situation with which you are not satisfied.

An Eligible grievant is:

1. A claimant;
2. Person authorized to act on behalf of the claimant. **Note:** The *member* will be asked to complete an Authorized Representative form to comply with the plan's HIPPA policies and to protect *member* confidential health information..
3. The *member's physician*, if the *member* has provided written consent for the provider to appeal on behalf of the *member*.
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.

Important: *Adverse benefit determinations* that are for services that are subject to medical review follow standard PPACA internal appeals processes.

Member verbal dissatisfaction not related to an adverse determination because of a benefit or a medical review follow the standard Complaint process.

Your rights to file formal grievance appeal of a denial of health benefits: You or your authorized representative, may file the grievance appeal for you, in writing, either by mail or by facsimile (fax). If you require assistance in filing a grievance or if you are unable to submit the grievance in writing, you can call at the number below to ask for help through the process, including communicating back to you. For an urgent request, you may also file a grievance by telephone.

Grievance/Appeals Unit
Sunshine Health
1301 International Parkway, Suite 400
Sunrise, FL 33323
Phone: 1- 877-687-1169
Fax: 1-800-225-2573

Grievances

Claimants have the right to submit written comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process.

Grievances will be promptly investigated and presented to the internal *grievance* panel. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing

advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an appeal.

Resolution Timeframes

1. *Grievances* regarding quality of care, quality of service, or *reformation* will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 30 calendar days (making the maximum time for the entire *grievance* process 60 calendar days) if we provide the *claimant* and the *claimant's* authorized representative, if applicable, written notification of the following within the first 30 calendar days:
 - a. That we have not resolved the *grievance*;
 - b. When our resolution of the *grievance* may be expected; and
 - c. The reason why the additional time is needed.
2. All other *grievances* will be resolved and we will notify the *claimant* in writing with the appeal decision within the following timeframes:
 - a. Post-service claim: within 60 calendar days after receipt of the *claimant's* request for internal appeal.
 - b. Pre-service claim: within 30 calendar days after receipt of the *claimant's* request for internal appeal.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The plan will give the claimant 10 calendar days to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new information.
2. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer, if the grievance is an appeal of an adverse determination subject to medical review. The plan will give the claimant 10 calendar days to respond to the new medical rationale before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

Refer to a later section for information regarding internal *expedited grievances*.

Acknowledgement

Within five business days of receipt of a *grievance*, a written acknowledgment to the claimant or the claimant's authorized representative confirming receipt of the *grievance* must be delivered or mailed and acknowledging that the grievance will be investigated and the claimant will be notified of the final decision in writing.

When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.

- (1) The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose.
- (2) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.
- (3) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.

Grievance Panel

The internal process requires that your appeal is handled by a grievance panel that does not include the person who made the initial determination or a subordinate of the original reviewer. During the grievance process, the initial decision maker may be consulted. The majority of the panel will consist of providers with the appropriate expertise. The panel must be requested within 30 days after Ambetter from Sunshine Health's transmission of an adverse determination. The panel will also provide a notice to the member and to the provider, if any, who filed on behalf of the member. In any case where the review process does not resolve a difference of opinion between the Ambetter from Sunshine Health and the member, the member (or provider) may submit a written grievance through an external review process. Members may voluntarily pursue binding arbitration (which you may incur some costs for this arbitration) after completing Ambetter from Sunshine Health's grievance procedure and as an alternative to the external review process (refer to the External Review section for more information). Arbitration shall not preclude review pursuant to Rule 690-191.081 and shall be conducted pursuant to Ch. 682, F.S.

When the *adverse benefit determination* is based in whole or in part on a medical judgment, the *grievance* panel will consult with a licensed health care provider with expertise in the field relating to the *grievance* and who was not consulted in connection with the original *adverse benefit determination*.

Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

A physician with knowledge of the member's health condition must submit an attestation to the health plan in writing about the urgency of the member's health status. The written attestation of medical urgency should note that a delay in treatment could seriously jeopardize your life or overall health, affect your ability to regain maximum function, or subject you to severe and intolerable pain.

An *expedited grievance* provides for evaluation by appropriate clinical peers or peer (who were not involved in the initial adverse determination) within 24 hours. An *expedited grievance* shall be resolved as expeditiously as the *claimant's* health condition requires but not more than 72 hours after receipt of the *grievance*. Written notification of the decision must be provided no later than 2 business days or three calendar days if the initial notification was not in writing.

A member has the right to request both an internal and external level expedited appeal, related to the denial of a service requiring medical review, simultaneously. If the expedited appeal is unresolved, the member may appeal through the external review process (refer to the External Review section for more information).

Upon written request, *we* will mail or electronically mail a copy of the claimant's complete policy to the claimant or the claimant's authorized representative as expeditiously as the *grievance* is handled.

Written Grievance/Appeal Response

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial, determination or initiation of disenrollment.

The panel's written decision to the grievant must include:

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *grievance*;
3. The signature of one voting member of the panel;
4. A written description of position titles of panel members involved in making the decision.
5. If upheld or partially upheld, it is also necessary to include:
 - a. A clear explanation of the decision;
 - b. Reference to the specific plan provision on which the determination is based;
 - c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
 - d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
 - e. If the *adverse benefit determination* is based on a medical necessity or *experimental treatment* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
 - f. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*;
 - g. The date of service;
 - h. The health care provider's name;
 - i. The claim amount;
 - j. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
 - k. The health plan's denial code with corresponding meaning;
 - l. A description of any standard used, if any, in denying the claim;
 - m. A description of the external review procedures, if applicable;
 - n. The right to bring a civil action under state or federal law;
 - o. A copy of the form that authorizes the health plan to disclose protected health information, if applicable;

- p. That assistance is available by contacting the specific state’s consumer assistance department, if applicable; and
- q. A culturally linguistic statement based upon the claimant’s county or state of *residence* that provides for oral translation of the *adverse benefit determination*, if applicable.

Complaints

Basic elements of a *complaint* include:

1. The complainant is the claimant or an authorized representative of the claimant;
2. The submission may or may not be in writing;
3. The issue may refer to any dissatisfaction about:
 - a. Us (as the insurer); e.g., member service *complaints* - “the person to whom I spoke on the phone was rude to me”.
 - b. Providers with whom *we* have a direct or indirect contract.
 - i. Lack of availability and/or accessibility of network providers not tied to an unresolved benefit denial.
Note: When the dissatisfaction is related to services from or access to a network provider, notify the Network Administration Department.
 - ii. Quality of care/quality of service issues;
4. Written expressions of dissatisfaction regarding quality of care/quality of service are processed as *grievances*.
5. Oral expressions of dissatisfaction regarding quality of care/quality of service are processed as *complaints* as indicated in standard oral *complaint* instructions; and
6. Any of the issues listed as part of the definition of *grievance* received from the *claimant* or the claimant’s authorized representative where the caller has not submitted a written request but calls us to escalate their dissatisfaction and request a verbal/oral review.

Complaints received from the Florida Office of Insurance Regulation

The Commissioner may require *us* to treat and process any *complaint* received by the Florida Office of Insurance Regulation by, or on behalf of, a claimant as a *grievance* as appropriate. *We* will process the Florida Office of Insurance Regulation *complaint* as a *grievance* when the Commissioner provides *us* with a written description of the *complaint*.

External Review

Ambetter members are offered two levels of appeal for adverse benefit determinations related to a service that requires medical review. An external review decision is binding on *us*. An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law. *We* will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility

The external review procedures apply to any hospital or medical policy or certificate; excluding accident only or disability income only insurance.

External review is available for *grievances* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer.
2. *Rescissions* of coverage.

After exhausting the internal review process, the claimant has 120 days to make a written request to the Appeals & Grievance Department for external review after the date of receipt of *our* internal response.

1. The internal appeal process must be exhausted before the claimant may request an external review unless the claimant files a request for an expedited external review at the same time as an internal *expedited grievance* or *we* either provide a waiver of this requirement or fail to follow the appeal process.
2. A health plan must allow a claimant to make a request for an expedited external review with the plan at the time the claimant receives:
 - a. An *adverse benefit determination* if the determination involves a medical condition of the claimant for which the timeframe for completion of an internal *expedited grievance* would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an internal *expedited grievance*.
 - b. A final internal *adverse benefit determination*, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.
3. Claimants may request an expedited external review at the same time the internal *expedited grievance* is requested and an Independent Review Organization (IRO) will determine if the internal *expedited grievance* needs to be completed before proceeding with the expedited external review.

External Review Process

1. We have five business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
 - a. The individual was a covered person at the time the item or service was requested;
 - b. The service is a *covered service* under the claimant's health plan but for the plan's *adverse benefit determination* with regard to medical necessity experimental/investigational, medical judgment, or *rescission*;
 - c. The claimant has exhausted the internal process; and
 - d. The claimant has provided all of the information required to process an external review.
2. Within one business day (immediately for expedited) after completion of the preliminary review, we will notify the claimant in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete. We will include notification of the member's right to submit written testimony to be included in the materials sent to the IRO.
3. We must allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of notification.
4. We will assign an IRO on a rotating basis from our list of contracted IROs.
5. Within five business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO.

Note: For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method.

6. If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*.
7. Within 10 business days, the assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the claimant may submit in writing additional information to the IRO to consider.
8. Upon receipt of any information submitted by the claimant, the IRO must forward the information to us within one business day.
9. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to the claimant and the IRO within one business day after making such decision. The external review would be considered terminated.
10. Within 45 days (72 hours for expedited) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the claimant and to us. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice.
11. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the covered benefit that was the subject of the *adverse benefit determination*.

State Appeals

If *you* do not accept the decision of the Panel, *you* have the right to appeal to the Florida Agency for Health Care Administration (AHCA) or the Department of Financial Services (DFS) within one (1) year from the date of receipt of *our* decision. If *you* appeal *our* final decision, *your* grievance will be reviewed by the Subscriber Assistance Program. *You* also have the right to contact AHCA or DFS at any time to inform them of an unresolved grievance.

The Subscriber Assistance Program will not hear a grievance if the *member* has not completed the entire Grievance process, nor if the *member* has instituted an action pending in the state or federal court.

Other Agencies

The Florida Agency for Health Care Administration and the Subscriber Assistance Program.
2727 Mahan Drive, Mail Stop 26
Tallahassee, Florida 32308
Telephones 1-888-419-3456 and 1-850-921-5458

The Florida Department of Financial Services
Division of Consumer Services
200 East Gaines Street
Tallahassee, Florida 32399
Toll-free: 1-877-693-5236
TDD: 1-800-640-0886

GENERAL PROVISIONS

Entire Contract

This *contract*, with the application and any rider-amendments is the entire contract between *you* and *us*. No change in this *contract* will be valid unless it is approved by one of *our* officers and noted on or attached to this *contract*. 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.

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*. that 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.

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.

We will provide the *member* forty-five (45) days advance written notice before coverage is rescinded.

Time Limit on Certain Defenses

Relative to a misstatement in the application, after 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability starting after the 2-year period.

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*. We will return any premium paid during the time period for which the member returned benefit payments.

Conformity with State Laws

Any part of this *contract* in conflict with the laws of the state in which your *contract* was issued on this *contract's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

Performance Outcomes and Financial Data

You may obtain information regarding performance outcomes and financial data for Celtic Insurance Company published by the State of Florida Agency for Health Care Administration by accessing Ambetter from Sunshine Health's website: www.ambetter.sunshinehealth.com. This website includes the link to FloridaHealthStat where this information is published, or you can go directly to www.floridahealthstat.com.