ambetter.
Insured by Celtic

2017 Evidence of Coverage

Ambetter Insured by Celtic
Underwritten by Celtic Insurance Company
EVIDENCE OF COVERAGE
Home Office: 77 W. Wacker Dr., Suite 1200, Chicago, IL 60601

Individual Member HMO 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 Ambetter Insured by Celtic.

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

You may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal 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) we withdraw from the service area or reach demonstrated capacity in a service area; (3) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

From time to time, *we* will change the rate table used for this *contract* form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, and age of *members,* type and level of benefits, and place of *residence* on the premium due date are some of the factors used in determining *your* premium rates. We have the right to change premiums after filing and approval by the state.

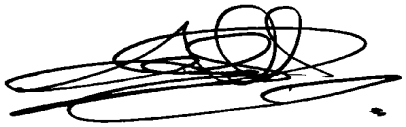
At least 31 day notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *contract* or a change in a *member's* health. While this *contract* is in force, *we* will not restrict coverage already in force. 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.

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.

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 claims paid, and the *contract* will be considered null and void from the *effective date*.

Ambetter Insured by Celtic



Anand Shukla,
SVP, Individual Health – Celtic Insurance Company

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INTRODUCTION

Welcome to Ambetter. 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, application, 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.

Throughout this contract you will also see references for Celtic Insurance Company and Ambetter Insured by Celtic. Both references are correct, as Ambetter Insured by Celtic operates under its legal entity, Celtic Insurance Company.

How to Contact Us
Ambetter Insured by Celtic
77 W. Wacker Dr., Suite 1200, Chicago, IL 60601

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. CST, Monday through Friday
Member Services **1-855-745-5507**
TDD/TTY line **1-866-565-8576**
Fax **1-866-900-7740**
Emergency **911**
24/7 Nurse Advise Line **1-855-745-5507 (24 hour nurse advice line)**

Interpreter Services
Ambetter Insured by Celtic 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 have 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 1-855-745-5507 (TDD/TTY 1-866-565-8576).

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*.

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 appeals 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 the following:
    a. Any changes in clinical review criteria
    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*.
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
18. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
19. 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.
20. 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.
21. 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*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
24. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
25. 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
    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* 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 Ambetter.IlliniCare.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 Provider" function on *our* website and selecting the IlliniCare Health Network. 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 1-855-745-5507. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. We* can also help *you* pick a *primary care physician* (PCP). 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 1-855-745-5507. *We* will help *you* make the appointment.

Your Member ID Card

When *you* enroll, *we* will mail you a *member* ID card to *you* within 5 business days of *our* receipt of *your* enrollment materials, which includes receipt of your initial binder payment. This card is proof that *you* are enrolled in Ambetter and is valid once *your* binder payment has been paid and enrollment processing is complete. *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 ID card will show *your* name, *member* ID#, and *copayment amounts* required at the time of service. If *you* do

not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-855-745-5507, twenty-four hours per day, seven days a week. *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 Ambetter.IlliniCare.com. It also gives *you* information on *your* benefits and services such as:

1. Finding a *network provider*.
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. Selecting a primary care provider.
6. Deductible and Co-payment Accumulators.
7. Making your payment.
8. Our programs and services.
9. The quarterly newsletter, Healthy Moves.
10. Member Rights and Responsibilities.
11. Notice of Privacy.
12. Current events and news.

You may also access the Federal Government's website at http://www.healthcare.gov/center/regulations/prevention.html to obtain current information.

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. 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 the 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 licensed practitioners* and performed for three or more hours per day, five to seven days per week, while the covered person is confined as an inpatient in a hospital, rehabilitation facility, or *extended care facility*.

Adverse benefit determination means:

1. Any claim denial, reduction, or termination of, or a failure to provide, or make payment for a benefit, including:
    a. Deductible credits; coinsurance; network provider reductions or exclusions, or other cost sharing requirements;
    b. Any instance where the plan pays less than the total expenses submitted resulting in *member* responsibility;
    c. A benefit resulting from the application of any utilization review;
    d. A covered benefit that is otherwise denied as not *medically necessary* or appropriate;
    e. A covered benefit that is otherwise denied as experimental or investigational;
2. 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
3. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the *member* 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 *member's* medical condition and that expertise is not available in the provider network.

Advanced premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. Advanced payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advanced credit payments to apply to your premiums each month, up to a maximum amount. If the amount of advanced credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advanced payments for the year are more than the amount of your credit, you must repay the excess advanced payments with your tax return.

Affordable Care Act "ACA" means the comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law. This is often times referred to as Health Care Reform.

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.

Applied behavior analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior,

including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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.

Autism spectrum disorder means autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical manual of Mental Disorders.

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.

Breast tomosynthesis means a radiologic procedure that involves the acquisition of projection images over the stationary breast, to produce cross-sectional digital three-dimensional images of the breast.

Case Management is a program in which a registered nurse, known as a case manager, assists a *member* through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and health care benefits available to a *member*. Case management is instituted at the sole option of us when mutually agreed to by the *member* and the *member's physician.*

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of *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.*

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*.

Civil Union means to allow same sex and different sex couples to eneter into a civil union with all the obligations, protections, and legal rights that Illinois provides to married heterosexual couples.

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 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, the applications, and any amendments.

Copayment, Copay or 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* application 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 (or ***coinsurance percentage***) means the percentage of *covered services* that is payable by a *covered person*.

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 expenses.

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

Dental services means *surgery* or services, including ancillary 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 spouse, civil union partner* 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..

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

a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
b) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
d) The trial does one of the following:
    i. Tests how to administer a health care service, item, or drug for the treatment of cancer;
    ii. Tests responses to a health care service, item, or drug for the treatment of cancer;
    iii. Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
    iv. Studies new uses of a health care service, item, or drug for the treatment of cancer.
e) The trial must meet the following criteria:
    i. The effectiveness of the treatment has not been determine relative to established therapies;
    ii. The trial is under clinical investigation as part of an approved cancer research trial in Phase II, Phase III, or Phase IV of investigation;
    iii. The trial is approved by the Food and Drug Administration; or
    iv. The trial is approved and funded by one of the following entities:
        a. National Institutes of Health, the Centers for Disease Control and Prevention, the Agency of Healthcare Research and Quality;
        b. The United States Department of Defense;
        c. The United States Department of Veterans' Affairs;
        d. The United States Department of Energy in the form of an investigational new drug application, or a cooperative group or center of any entity described.
    v. The patient's primary care physician, if any, is involved in the coordination of care

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 stepchild;
4. A child placed with *you* for adoption;
5. 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*; or
6. A child who is in your custody, pursuant to an interim court order of adoption.

Coverage is extended for unmarried *eligible child* under the age of 30 if the dependent:

- is an Illinois resident;

- served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; and
- has received a release or discharge other than a dishonorable discharge.

To be eligible for coverage, the eligible unmarried *eligible child* shall submit to Ambetter a form approved by the Illinois Department of Veterans' Affairs stating the date on which the unmarried *eligible child* was released from service.

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

1. For *network providers:* When a *covered* expense 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*, 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 greater of the following (*you* will not be balanced billed by the provider, if *you* are, please contact Member Services):
        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 in-network providers for the covered service. If there is more than one contract amount with in-network providers for the covered service, the amount is the median of these amounts.
    b. 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 amount that would be paid under Medicare (*you* will not be balanced billed by the provider, if *you* are, please contact Member Services).
    c. When a *covered service* is received from a *non-network provider* upon referral by *your primary care physician* because the service or supply is not of a type provided by any *network provider* and is needed for ongoing care to treat a specific condition, the *eligible service expense* is the lesser of (1) the negotiated fee, if any, that the provider has agreed to accept as payment in full; or (2) the provider's billed charge.

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, 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.

Emergency means a medical condition manifesting itself by such acute symptoms of sufficient severity (including, but not limited to, severe pain) that a prudent layperson with 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.

If *you* are experiencing an emergency, call 9-1-1 or go to the nearest *hospital*

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 *membe*r to regain maximum function;
2. In the opinion of a physician with knowledge of the *member'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*; and
3. A physician with knowledge of the *member'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 (*"USFDA"*) regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to *USFDA* approval, and:
    a. It does not have *USFDA* approval;
    b. It has *USFDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *USFDA* 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 *USFDA*-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;* or
    d. It has USFDA approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the USFDA 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 *USFDA* 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 standards of medical practice for that condition.

Extended care facility does not include a facility primarily for rest, the aged, treatment of *substance use disorder, 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 that are based on physician specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service* under the *contract*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

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 *member* including any of the following:

1. Provision of services;
2. Determination to reform or rescind a contract;
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 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*.

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 direct 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*.

Immunosuppressant drugs mean drugs that are used in immunosuppressive therapy to inhibit or prevent the activity of the immune system. "Immunosuppressant drugs" are used clinically to prevent the rejection of transplanted organs and tissues. "Immunosuppressant drugs" do not include drugs for the treatment of autoimmune diseases or diseases that are most likely of autoimmune origin.

Infertility means the inability to conceive after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility, or the inability to sustain a successful pregnancy.

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, for medical, behavioral health and substance use, 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 licensed practitioners* and performed for three or more hours per day, five to seven days per week.

Intoxicated means that which is defined and determined by the laws of jurisdiction where the loss or cause of the loss was incurred.

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

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), however this will not apply to a dependent living outside the service area if a court order requires the *member* to cover the dependent ;
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 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.
5. 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.
6. 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.

Low-dose Mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than 1 rad per breast for 2 views of an average size breast (also includes digital mammography).

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 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 expenses*. 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 a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *contract:* acupuncturist, speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *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.

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. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. Is provided in the most cost effective care facility or setting;
7. 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
8. 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 Necessary medical supplies mean medical supplies that are:

1. Medically Necessary to the care or treatment of an *injury* or *illness*;
2. Not reusable or *durable medical equipment*; and
3. Not able to be used by others.

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

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; and
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 health 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. It includes, but is not limited to: schizophrenia, paranoid and other psychotic disorders, bipolar disorders (hypomanic, manic, depressive and mixed), major depressive disorders (single episode or recurrent), schizoaffective disorders (bipolar or depressive), pervasive developmental disorders, obsessive-compulsive disorders, depression in childhood and adolescence, panic disorder, post-traumatic stress disorders (acute, chronic, or with delayed onset), and anorexia nervosa and bulimia nervosa.

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 *contract*.

Opioid Antagonist means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors.

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 mean 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. 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 expenses*.

Prescription order means the request for each separate drug or medication by a *physician* or each authorized refill or such requests.

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, OB-GYN physician or internist.

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 issued or recognized by each Health Insurance Marketplace through which such plan is offered.

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.

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

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

Rescission of a *contract* means a cancellation or discontinuance of coverage that has a retroactive effect. Rescission does not include a cancellation or discontinuance or coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

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

Service area means a geographical area, made up of counties, where we have been authorized by the State of Illinois to sell and market our health plans. This is where the majority of our Participating Providers are located where you will receive all of your health care services and supplies. You can receive precise service area boundaries from our website or our Member Services department.

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

Spouse means *your* lawful wife or husband or, if you are a party to a *civil union* under the Illinois Religious Freedom Protection and Civil Union Act, the other party to such *civil union*.

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

Substance use disorder means alcohol, drug or chemical abuse, overuse, or dependency. It includes, but is not limited to: substance abuse disorders, substance dependence disorders, and substance induced disorders.

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

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

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 newborns birth; or
3. The date that an adopted child is placed with the subscriber for the purposes of adoption, when an eligible child is placed in the custody of you and your spouse pursuant to an interim court order of adoption vesting temporary care of the child to you or your spouse, regardless of whether a final order granting adoption is ultimately issued 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 *contract* will be covered on *your effective date*.

Coverage for a Newborn Child
An *eligible child* born to *you* or a family *member* will be covered from the time of birth until the 31st day after its birth. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. Notice of the newborn must be given to *us* within 31 days after the date of birth in order to have the coverage continue after the 31 day period and will require payment of the additional premium. 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 of the child will terminate on the 31st day after its birth, unless *we* have received notice by the Marketplace of the child's birth.

Coverage for an Adopted Child
An *eligible child* legally placed for adoption with *you* or *your spouse* will be covered from the date of *placement* until the 31st day after *placement,* unless the *placement* is disrupted prior to legal adoption and the child is removed from *your* or *your spouse's* custody.

The child will be covered for *loss* due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of *placement.*

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child. Notice of the *placement* must be given to *us* within 31 days after the *placement* in order to have the coverage continue after the 31 day period and will require payment of the additional premium. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st 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 assumption and retention by you or your spouse for total or partial support of the child in anticipation of the adoption of the child. . Placement includes when an eligible child is placed in the custody of you or your spouse pursuant to an interim court order of adoption vesting temporary care of the child in you or your spouse, regardless of whether a final order granting adoption is ultimately issued.

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* has failed to pay premiums or contributions in accordance with the terms of this contract or the date that we have not received timely premium payments in accordance with the terms of this contract; or
2. The date the member has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact (e.g., the date that a member accepts any contributions or reimbursement by or on behalf of an employer, for any portion of the premium for coverage under this contract; or
3. 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; or
4. The date the primary *member* no longer resides, lives or works in the Service Area of this plan; or
5. The date *we* decline to renew this *contract*, as stated in the Discontinuance provision; or
6. The date of a covered person's death.

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*.

All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*.

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 disability or physical disability that began before the age limit was reached; and
2. Mainly dependent on *you* for support.

Dependent Medical Leave of Absence
Coverage will continue for a *dependent member* college student who takes a medical leave of absence or reduces his or her course load to part-time status because of a catastrophic illness or injury. Continuation of coverage for such a dependent member college student will automatically terminate 12 months after notice of the illness or injury or until coverage would have otherwise lapsed pursuant to the terms and conditions of this contract, whichever comes first, provided the need for part-time status or medical leave of absence is supported by a clinical certification of need from a physician licensed to practice medicine in all its branches.

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 1, 2016 and extends through January 31, 2017. *Qualified individuals* who enroll prior to December 15, 2016 will have an *effective date* of coverage on January 1, 2017. *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 2016 and January 31, 2017, 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 *advanced payments of the premium tax credit* 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 *advanced payments of the premium tax credit* and *cost-*

sharing reduction payments until the first of the next month. *We* will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special 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*; or
2. A *qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption or placement for adoption; or
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status; or
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, intentional 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, intentional misrepresentation, or inaction; or
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; or
6. An individual is determined newly eligible or newly ineligible for *advanced payments of the premium tax credit* or has a chance in eligibility for *cost-sharing reductions*, regardless of whether such individual is already enrolled in a *qualified* health plan; or
7. A *qualified individual* or enrollee gains access to new qualified health plans as a result of a permanent move; or
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended; or
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.

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 20th of the month in which coverage is effective.

Grace Period
When a *member* is receiving a premium subsidy:
After the first premium is paid, a grace period of 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 31 days of the grace period, if advanced premium tax credits are received.

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first 31 days 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 advanced premium tax credits on behalf of the *member* from the Department of the Treasury, and will return the advanced premium tax credits on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above.

When a member is not receiving a premium subsidy:
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 31 day 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; however, claims may pend for *covered services* rendered to the *member* during the grace period. *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.

Third Party Payment
We will accept payments on the *member's* behalf from the following third party payers:
1. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations or urban Indian organizations; or
3. State and Federal Government programs.

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* may charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

MEDICAL SERVICE 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 amoun*t 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: Except for services or supplies provided for an emergency or by a non-network provider when no network provider is available and when authorized by us, 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* may be 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* must designate a *network primary care physician* for each *member. You* may select any *network primary care physician* who is accepting new patients. For children, *you* may designate a pediatrician as a *network primary care physician*. Women may designate an OB/GYN as a *network primary care physician*. 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* identification card. 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.

Provider Contracts: Notice of Nonrenewal or Termination
We will provide at least 60 days' notice of nonrenewal or termination of a health care *provider* to the health care *provider* and to the *members* served by the health care *provider*. The notice shall include a name and address to which a *member* or health care *provider* may direct comments and concerns regarding the nonrenewal or termination. Immediate written notice may be provided without 60 days' notice when a health care *provider's* license has been disciplined by a State licensing board.

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 contract* or benefits payable under this *contract* will be reduced. If you have a condition that requires ongoing care from a specialist physician or other health care provider and a referral is required under this contract, you may apply to your primary care physician for a standing referral. You may contact us to learn more about the criteria and conditions related to obtaining a standing referral.

Service Area
Ambetter operates in a limited service area. If you move from one county to another within the service area your premium may be increased or changed. If you move from one county in the service area to another that is not in the service area you are no longer eligible for coverage under this contract, and will be eligible for special enrollment into another Qualified Health Plan.

Coverage Under Other Contract 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*, in cases of *emergency*.
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 Insured by Celtic.

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. 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.
4. Ambulance services provided for a *member's* comfort or convenience.
5. Non-emergency transportation excluding ambulances.

Mental Health and Substance Use (including Alcoholism) Disorder Benefits
Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter. 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 PCP 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 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 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 American Society of Addiction Medicine criteria for *substance use disorder* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not medically necessary will be made by a qualified licensed mental health professional.
Covered Inpatient, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient
1. Inpatient treatment;
2. *Emergency* services for mental health and substance use disorder;
3. Observation;
4. Crisis Stabilization;
5. Residential Treatment Facility;
6. Rehabilitation;
7. Clinically managed detoxification services in a substance use disorder facility; and
8. Electroconvulsive Therapy (ECT).

Intermediate
1. Partial Hospitalization Program (PHP);
2. Intensive Outpatient Program (IOP);
3. Day treatment; and
4. Residential Detoxification.

Outpatient
1. Traditional outpatient services, including individual and group therapy services;
2. Diagnosis Treatment;
3. Medication management services;
4. Applied Behavior Analysis Based Therapies and autism spectrum disorders;
5. Neuropsychological testing;
6. Psychological Testing; and
7. Rehabilitation.

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 Expense Benefits

Covered service expenses provided for *medically necessary Habilitation* services shall include:

a. Out-patient physical *Rehabilitation* services including speech and language therapy and/or occupational therapy, performed by a licensed therapist.
b. Clinical therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to applied behavioral analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan.
c. Mental/behavioral health outpatient services performed by a licensed psychologist, psychiatrist, or *Physician* to provide consultation, assessment, development and oversight of treatment plans.

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

Autism Spectrum Disorder Expense Benefit
Autism spectrum disorder coverage for the diagnosis of *autism spectrum disorders* and for the *treatment of autism spectrum disorders* to the extent that the diagnosis and treatment of *autism spectrum disorders*.

- Upon request by *us*, a *provider* of treatment for *autism spectrum disorders* shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is *medically necessary* and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, *we* may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.
- When making a determination of medical necessity for a treatment modality for *autism spectrum disorders*, *we* will make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under this *contract*, including an appeals process. During the appeals process, any challenge to *medical necessity* must be viewed as reasonable only if the review includes a physician with expertise in the most current and effective treatment modalities for *autism spectrum disorders*. Coverage for *medically necessary* early intervention services must be delivered by certified early intervention specialists.
- Coverage of *autism spectrum disorders* will also include applied behavior analysis that is intended to develop, maintain, and restore the functioning of an individual.

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. Services of a private duty registered nurse rendered on an outpatient basis.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Hospital laboratory services.
8. Rental of the medically necessary *durable medical equipment*.

Charges under (4) and (7) 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 *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 applies to a *member* that has a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care.

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. Coordinated Home Care*.*
3. Medical supplies and dressings.
4. Medications.
5. Skilled and non-skilled nursing services.
6. Physical and occupational therapy.
7. Speech-language therapy.
8. Physician visits.
9. 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.*
10. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
11. Counseling the *member* regarding his or her *terminal illness.*
12. *Terminal illness counseling* of the *member's immediate family.*
13. *Bereavement counseling,* refer to your Schedule of Benefits.
14. Social and spiritual services.
15. Respite Care Services.

Rehabilitation and Skilled Nursing Facility Expense Benefits
Covered service expenses include services provided or expenses incurred for *rehabilitation* services or confinement in a *skilled nursing facility*, subject to the following limitations:

1. *Covered service expenses* available to a *member* while confined primarily to receive *rehabilitation* are limited to those specified in this provision.
2. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *skilled nursing facility* for:
    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.
3. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*

In accordance with the terms of this contract, up to 60 treatments per year of outpatient rehabilitative therapy and cardiac rehabilitative therapy that is medically necessary and authorized by us will be covered for conditions that are expected to result in significant improvement within two months as determined by your primary care physician.

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*.

Respite Care *Expense Benefits*

Respite care is covered on an inpatien*t* or outpatient basis to allow temporary relief to family *members* from the duties of caring for a Covered Person under Hospice Care. Respite days that are applied toward the Deductible are considered benefits provided and shall apply against any Maximum Benefit limit for these services.

Medical Foods

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

Chiropractic and Osteopathic Services

We cover charges for chiropractic and osteopathic services. These services shall be provided at the request of the enrollee who presents a condition of an orthopedic or neurological nature necessitating treatment for which falls within the scope of a licensed chiropractor or osteopath. See the Schedule of Benefits for benefit levels or additional limits.

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 oxygen and its administration.
12. For *dental service expenses* related specifically and directly to a medical condition.
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. Oral surgery/TMJ services and devices, limited to:
    a. surgical removal of complete bony impacted teeth;
    b. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    c. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    d. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.
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 will include: inpatient treatment following mastectomy for length of time to be determined by attending physician; and availability of post-discharge physician office visit or in-home nurse visit within 48 hours of discharge. Coverage includes all *medically necessary* pain medication and pain therapy related to the treatment of breast cancer. As used here, "pain therapy" means pain therapy that is medically based and includes reasonably defined goals, including, but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.
16. 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; insulin pumps; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
17. For Child wellness services. This includes the periodic review of a child's physical and emotional status conducted by a physician or conducted pursuant to a physician's supervision, but shall not include periodic dental examinations or other dental services. The review shall include a medical history, complete physical examination, developmental assessment, appropriate immunizations, anticipatory guidance for the parent or parents, and laboratory testing in keeping with prevailing medical standards. These services are limited to an eligible child under the age of 19 years.
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.
    e. Implantable prosthetic lenses, in connection with cataracts.
19. Family Planning for certain professional Provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices. Medical history review, physical examinations, laboratory tests related to physical examinations, contraceptive counseling and all FDA-approved contraception methods are covered without cost sharing. This benefit contains both pharmaceutical and medical methods, including: intrauterine devices (IUD), including insertion and removal; barrier methods including: male and female condoms (Rx required from Provider, limited to 30 per month), diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide and spermicide alone; oral contraceptives including the pill (combined pill and extended/continuous use), and the mini pill (Progestin only), patch; other hormonal contraceptives, including inserted and implanted contraceptive devices, hormone contraceptive injections and the vaginal contraceptive ring; emergency contraception (the morning after pill).

20. Allergy testing, injections and serum.
21. X-ray and other radiology services.
22. Magnetic Resonance Imaging (MRI).
23. CAT scans.
24. Positron emission tomography (PET scanning).
25. Coverage for a complete and thorough clinical breast examination for the purpose of early detection and prevention of breast cancer at the following intervals:
    a. At least every 3 years for women 20 years of age and under 40 years of age; and
    b. Annually for women 40 years of age or older.

    Coverage include services provided by a *physician,* an advanced practice nurse who has a collaborative agreement with a collaborating physician that authorizes breast examinations or a physician assistant who has been delegated authority to provide breast examinations
26. Dental anesthesia charges incurred, in conjunction with dental care that is provided to a *member* in a *hospital* or an *ambulatory care facility* if any of the following applies:
    a. the *member* is a child age 6 or under;
    b. the *insured person* has a medical condition that requires hospitalization or general anesthesia for dental care; or
    c. the *member* is disabled.

    Disabled means a *member*, regardless of age, with a chronic disability if the chronic disability meets all of the following conditions. It is attributable to a mental or physical impairment or combination of mental and physical impairments:
    a. It is likely to continue;
    b. It results in substantial functional limitations in one or more of the following areas of major life activity:
        - self-care;
        - receptive and expressive language;
        - learning;
        - mobility;
        - capacity for independent living; or
        - economic self-sufficiency.
27. Following a recommendation for elective surgery. Coverage will be provided at 100% of claim charge for one consultation and related diagnostic service by a physician. If requested, benefits will be provided for an additional consultation when the need for surgery, in your opinion, is not resolved by the first consultation;
28. Coverage for outpatient end stage renal disease treatment including both outpatient and in-patient settings based on medical necessity;
29. Coverage for any emergency, other medical or hospital expense, if *member* is intoxicated or under the influence of any narcotic, regardless of whether the intoxicant or narcotic is administered on the advice of a health care practitioner;
30. Coverage for routine physical examinations for expenses incurred in the examination and testing of a victim of a criminal sexual assault or abuse. The deductible or coinsurance will not apply;
31. Annual digital rectal examination and prostate-specific antigen test for males upon recommendation of physician. Must include asymptomatic men age 50 and over; African-American men age 40 and over; and men age 40 and over with family history of prostate cancer.
32. *Medically necessary* treatment for varicose and spider veins treatment.
33. Bariatric Surgery.
34. For Naprapathic Services. See the Schedule of Benefits for benefit levels or additional limits.
35. Preventive services for the treatment of obesity.
36. Coverage for *durable medical equipment.*

Infertility Expense Benefits

Infertility coverage for the diagnosis and treatment of infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer.
Coverage for procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer shall be required only if:

a. the *member* has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments for which coverage is available under the contract; and
b. the procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

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 Ambetter.IlliniCare.com or by contacting Member Services by telephone at 1-855-745-5507. 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.

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.
10. *Medically necessary* amino acid-based elemental formula for the diagnosis and treatment of (i) eosinophilic disorders and (ii) short bowel syndrome when prescribed by a *physician*.
11. Contraceptive coverage for a *member* and any *dependent* for all FDA-approved contraception methods are approved for *members* without cost sharing as required under the Affordable Care Act. Members have access to the methods available and outlined on our Drug Formulary or Preferred Drug List without cost share. Some contraception methods are available through a *member's* medical benefit, including the insertion and removal of the contraceptive device at no cost share to the *member*. Emergency contraception is available to *members* without a prescription and at no cost share to the *member*.
12. Shingles coverage for a vaccine for shingles that is approved for marketing by the Federal Food and Drug Administration if the vaccine is ordered by a *physician* licensed to practice medicine in all its branches and the *member* is 60 years of age or older.
13. Coverage for Preventative Physical Therapy for Multiple Sclerosis Patients. As used here, "preventative physical therapy " means physical therapy that is prescribed by a physician licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only

where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.

14. Coverage for Pulmonary Rehabilitation Therapy.
15. Coverage for Cardiac Outpatient Rehabilitation Services.
16. Coverage for osseointegrated auditory implants.
17. Routine hearing exams and hearing aids for children up to 19 years of age.
18. Coverage for *medically necessary* massage therapy.

Outpatient Prescription Drug Expense Benefits

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

1. A retail, mail order, generic, brand and specialty *prescription drug;*
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician;*
3. Self-injectibles medications;
4. Insulin/needles for diabetes;
5. Fertility drugs;
6. Biological drugs;
7. Topical eye medication when the medication is to treat a chronic condition of the eye, the refill requested by the *member* prior to the last day of the prescribed dosage period and after at least 75% of the predicted days of use and the prescribing physician licensed to practice medicine in all its branches or optometrist indicates on the original prescription that refills are permitted and that the early refills requested by the *member* do not exceed the total number of refills;
8. Opioid antagonist; and
9. Growth hormone therapy.

See the Schedule of Benefits for 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.*

Formulary means our list of covered drugs available on our website at Ambetter.IlliniCare.com or by calling our Member Services department.

- Generic drug is a drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the FDA as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. Generic drugs will be dispensed whenever available.
- Brand drug is a Prescription Drug that has been patented and is only available through one manufacturer. Preferred Brand drugs will be dispensed if there is not a generic. Brand drugs are also often preferred because they are safer or more successful in producing a desired or intended result.
- Non-Preferred drug is a Prescription Drug covered under a higher cost share. This tier of drug contains both formulary brand name and generic drugs. These drugs require higher copay because other alternatives may be available in the lower tiers or there may be other generic equivalents available.
- Specialty drugs are typically high-cost drugs, including but not limited to the oral, topical, inhaled, inserted or implanted, and injected routes of administration. Included characteristics of Specialty drugs are drugs that are used to treat and diagnose rare or complex diseases, require close clinical monitoring and management, frequently require special handling, and may have limited access or distribution. Specialty drugs are often also drugs that require special handling, or special or enhanced patient administration and oversight.

Non-Formulary Prescription Drugs:

Under Affordable Care Act, you have the right to request coverage of prescription drugs that are not listed on the plan formulary (otherwise known as "non-formulary drugs"). To exercise this right, please get in touch with your medical practitioner. Your medical practitioner can utilize the usual prior authorization request process. See "Prior Authorization" below for additional details.

Our formulary is reviewed and updated on a quarterly basis following Pharmacy and Therapeutics Committee meeting. Pharmacy and Therapeutics Committee reviews all new drug arrivals (brand and generic) and determines their placement on the Formulary. Positive formulary changes, such as moving drugs to lower tier, removal of quantity limits, removal of utilization management edits (PA/ST) or addition of new brand name drugs take place shortly after the Pharmacy and Therapeutics Committee approves such changes.

Negative changes to our formulary, such as removal of the drug from coverage, moving drug to a higher tier, addition of utilization management edits (PA/ST) take place once a year at the start of the new benefit (January 1st).

Prescription Drug Exception Process

Standard exception request

A *member*, a *member's* designee or a *member's* prescribing *physician* may request a standard review of a decision that a drug is not covered by the plan. The request can be made in writing or via telephone. Within 72 hours of the request being received, we will provide the *member*, the *member's* designee or the *member's* prescribing *physician* with our coverage determination. Should the standard exception request be granted, we will provide coverage of the non-formulary drug for the duration of the prescription, including refills.

Expedited exception request

A *member*, a *member's* designee or a *member's* prescribing *physician* may request an expedited review based on exigent circumstances. Exigent circumstances exist when a *member* is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. Within 24 hours of the request being received, we will provide the *member*, the *member's* designee or the *member's* prescribing *physician* with our coverage determination. Should the standard exception request be granted, we will provide coverage of the non-formulary drug for the duration of the exigency.

External exception request review

If *we* deny a request for a standard exception or for an expedited exception, the *member*, the *member's* designee or the *member's* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. *We* will make our determination on the external exception request and notify the *member*, the *member's* designee or the *member's* prescribing *physician* of *our* coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.

If *we* grant an external exception review of a standard exception request, *we* will provide coverage of the non-formulary drug for the duration of the prescription. If *we* grant an external exception review of an expedited exception request, *we* will provide coverage of the non-formulary drug for the duration of the exigency.

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 unless listed on the formulary.
2. For immunization agents, except when used for preventive care or required by the Affordable Care Act.
3. For medication that is to be taken by the *member,* 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. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
7. 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 preventive care.
8. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
9. 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.
10. For more than a 31-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
11. 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.

Special Rules for Prescription Drug Coverage:

1. The financial requirements applicable to orally-administered cancer medications may be no different than those same requirements applied to intravenously administered or injected cancer medications.
2. Coverage for prescribed drugs for certain types of cancer shall not exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration if proper documentation, as outlined, is provided. Such coverage shall also include those *medically necessary* services associated with the administration of such drugs.
3. We will not deny or limit coverage for prescription inhalants when diagnosis is for asthma or other life-threatening bronchial ailments.

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.

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

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 contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of eyeglasses every calendar year; and
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 which includes cervical cancer and HPV screening, colorectal cancer screening, ovarian cancer screening, prostate cancer screening and mammography

screening.
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.

The preventive care services described in items 1 through 4 may change as USPSTF, CDC and HRSA guidelines are modified.

Covered Preventive Services for Adults including:

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked;
2. Alcohol Misuse screening and counseling;
3. Aspirin use for men and women of certain ages;
4. Blood Pressure screening for all adults;
5. Cholesterol screening for adults of certain ages or at higher risk;
6. Colorectal Cancer screening for adults over 50;
7. Depression screening for adults;
8. Type 2 Diabetes screening for adults with high blood pressure;
9. Diet counseling for adults at higher risk for chronic disease;
10. HIV screening for all adults at higher risk;
11. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza (Flu Shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella;
12. Obesity screening and counseling for all adults;
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
14. Tobacco Use screening for all adults and cessation interventions for tobacco users; and
15. Syphilis screening for all adults at higher risk.

Covered Preventive Services for Women and Pregnant Women include:

1. Anemia screening on a routine basis for pregnant women;
2. Bacteriuria urinary tract or other infection screening for pregnant women;
3. BRCA counseling about genetic testing for women at higher risk;
4. One cytologic screening per year or more often if recommended by a physician;
5. Screening Mammography for all women over 35, baseline mammogram for women 35 to 39 years of age and annual mammogram for women 40 years of age and older, for women under 40 with a family history of breast cancer or other risk factors mammograms are covered at an age and interval considered medically necessary, a comprehensive ultrasound screening of an entire breast or breasts when a mammogram demonstrates medical necessity as described, a screening MRI when medically necessary, as determined by a physician, and a breast tomosynthesis.
6. Breast Cancer Chemoprevention counseling for women at higher risk;

7. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;
8. Cervical Cancer screening for sexually active women;
9. Chlamydia Infection screening for younger women and other women at higher risk;
10. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
11. Domestic and interpersonal violence screening and counseling for all women;
12. Folic Acid supplements for women who may become pregnant;
13. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
14. Gonorrhea screening for all women at higher risk;
15. Hepatitis B screening for pregnant women at their first prenatal visit;
16. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women;
17. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older;
18. Coverage for medically necessary bone mass measurement and for diagnosis and treatment of osteoporosis;
19. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
20. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant; tobacco users;
21. Sexually Transmitted Infections (STI) counseling for sexually active women;
22. Syphilis screening for all pregnant women or other women at increased risk; and
23. Well-woman visits to obtain recommended preventive services.

Covered Preventive Services for Children including:

1. Alcohol and Drug Use assessments for adolescents;
2. Autism screening for children at 18 and 24 months;
3. Behavioral assessments for children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10; years, 11 to 14 years, 15 to 17 years.
4. Blood Pressure screening for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
5. Cervical Dysplasia screening for sexually active females;
6. Congenital Hypothyroidism screening for newborns;
7. Depression screening for adolescents;
8. Developmental screening for children under age 3, and surveillance throughout childhood;
9. Dyslipidemia screening for children at higher risk of lipid disorders. Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
10. Fluoride Chemoprevention supplements for children without fluoride in their water source;
11. Gonorrhea preventive medication for the eyes of all newborns;
12. Hearing screening for all newborns;
13. Height, Weight and Body Mass Index measurements for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
14. Hematocrit or Hemoglobin screening for children;
15. Hemoglobinopathies or sickle cell screening for newborns;
16. HIV screening for adolescents at higher risk;
17. Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis;
    - Haemophilus influenzae type b;
    - Hepatitis A;
    - Hepatitis B;
    - Human Papillomavirus;

- Inactivated Poliovirus;
- Influenza (Flu Shot);
- Measles, Mumps, Rubella;
- Meningococcal;
- Pneumococcal;
- Rotavirus;
- Varicella.

18. Iron supplements for children ages 6 to 12 months at risk for anemia;
19. Lead screening for children at risk of exposure;
20. Medical History for all children throughout development. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
21. Obesity screening and counseling;
22. Oral Health risk assessment for young children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years;
23. Phenylketonuria (PKU) screening for this genetic disorder in newborns;
24. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
25. Tuberculin testing for children at higher risk of tuberculosis. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years; and
26. Vision screening for all children.

Benefits for preventive health services listed in this provision are exempt from any *deductibles, cost sharing percentage* provisions, and *copayment amounts* under the *contract* when the services are provided by 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.

Notification
As required by PHS Act section 2715(d)(4), we will provide 60 days advance notice to *you* before any material modification will become effective, including any changes to preventive benefits covered under this *contract*.

You may access *our* website or the Member Services Department at 1-855-745-5507to get the answers to many of *your* frequently asked questions regarding preventive services. *Our* website has resources and features that make it easy to get quality care. *Our* website can be accessed atAmbetter.IlliniCare.com.

You may also access the Federal Government's website at
http://www.healthcare.gov/center/regulations/prevention.html to obtain current information.

Newborns' And Mothers' Health Protection Act Statement Of Rights

Covered Services for Maternity Care:
Outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, prenatal HIV testing, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other medically necessary reasons (less any applicable copayments, deductible amounts, or cost sharing percentage). An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include complications of pregnancy, parent education, assistance, and training in breast or bottle feeding, including the purchase or rental of breast pumps, 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.
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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.

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.

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:
If *we* determine that a *member* is an appropriate candidate for a *transplant,* Medical Service Expense Benefits will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting.
3. Immunosuppressant drugs.
4. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *member* to prepare for a later transplant, whether or not the transplant occurs.
5. High dose chemotherapy.
6. Peripheral stem cell collection.
7. The transplant itself, not including the acquisition cost for the organ or bone marrow (except at a *Center of Excellence*).
8. Post-transplant follow-up.
9. Transportation for the *member*, any live donor, and the *immediate family* to accompany the *member* to and from the facility where the transplant will be performed. Lodging for the *member*, any live donor and the immediate family accompanying the *member* while the *member* is confined. We will pay the costs directly for transportation and lodging up to a maximum of $10,000 per transplant, however, you must make the arrangements. Maximum for lodging per person, per day, is $50.

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 *transplant.*

Ancillary "Center Of Excellence" Service Benefits:
A *member* may obtain services in connection with a *transplant* from any *physician*. However, if a *transplant* is performed in a *Center of Excellence, Covered service expenses* for the *transplant* will include the acquisition cost of the organ or bone marrow.

Benefits are available to both the recipient and donor of a covered transplant as follows: (1) If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own

program. (2) If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this *contract* will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits. (3) If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this *contract* will be provided for you. However, no benefits will be provided for the recipient. Benefits will be provided for: (1) Inpatient and Outpatient Covered Services related to the transplant Surgery. (2) The evaluation, preparation and delivery of the donor organ. (3) The removal of the organ from the donor. (4) The transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada. Benefits will only be provided at in-network approved Human Organ Transplant Coverage Program.

Non-Covered Services And Exclusions:
No benefits will be provided or paid under these Transplant Expense Benefits:

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *transplant* occurs.
2. For animal to human transplants.
3. To keep a donor alive for the transplant operation.
4. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
5. Related to transplants not included under this provision as a transplant.
6. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("USFDA") regulation, regardless of whether the trial is subject to USFDA oversight.

Organ Transplant Medication Notification
At least 60 days prior to making any formulary change that alters the terms of coverage for a patient receiving immunosuppressant drugs or discontinues coverage for a prescribed immunosuppressant drug that a patient is receiving, we must, to the extent possible, notify the prescribing physician and the patient, or the parent or guardian if the patient is a child, or the spouse of a patient who is authorized to consent to the treatment of the patient. The notification will be in writing and will disclose the formulary change, indicate that the prescribing physician may initiate an appeal, and include information regarding the procedure for the prescribing physician to initiate the *contract*'s appeal process.

As an alternative to providing written notice, we may provide the notice electronically if, and only if, the patient affirmatively elects to receive such notice electronically. The notification shall disclose the formulary change, indicate that the prescribing physician may initiate an appeal, and include information regarding the procedure for the prescribing physician to initiate the *contract*'s appeal process.

At the time a patient requests a refill of the immunosuppressant drug, we may provide the patient with the written notification required above along with a 60-day supply of the immunosuppressant drug under the same terms as previously allowed.

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.*

Prior Authorization requests must be received by phone/efax/Provider portal as follows:

1. At least 5 days prior to an elective admission as an inpatient in a Hospital, extended care or Rehabilitation facility, or Hospice facility.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. At least 5 days prior to a scheduled inpatient behavioral health or Substance Use treatment admission.
5. At least 5 days prior to the start of Home Health Care.

After prior authorization has been requested and all required or applicable documentation has been submitted, we will notify you and your Provider if the request has been approved as follows:

1. For immediate request situations, within 1 business day, when the lack of treatment may result in an emergency room visit or emergency admission.
2. For urgent concurrent review within 24 hours of receipt of the request.
3. For urgent pre-service, within 72 hours from date of receipt of request.
4. For non-urgent pre-service requests within 5 days but no longer than 15 days of receipt of the request.
5. For post-service requests, with in 30 calendar days of receipt of the request.

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. There is a penalty if treatment is not authorized prior to service. The penalty is a 20% reduction of the eligible expenses for all charges related to the treatment, not to exceed $1,000. The penalty applies to all otherwise eligible expenses that are:

- Incurred for treatment without prior authorization;
- Incurred during additional *hospital* days without prior authorization; or
- Determined to be inappropriately authorized following a retrospective review, or inappropriately authorized due to intentional misrepresentation of facts or false statements.

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.*

If *we* authorize a proposed admission, treatment, or *covered service expense* by a *network provider* based upon the complete and accurate submission of all necessary information relative to an eligible *member*, *we* shall not retroactively deny this authorization if the *network provider* renders the *covered service expense* in good faith and pursuant to the authorization and all of the terms and conditions of the *network provider's* contract with *us*.

Transition of Services
We shall notify new *members* and current *members* of the availability of transitional services for conditions that require ongoing course of treatment.

New *members* must request the option of transitional services in writing, within 15 days after receiving notification of the availability of transitional services.

Members whose *physician* leaves the *network* of health care providers shall request the option of transitional services in writing within 30 days after receipt of notification of termination of the *physician*.

Within 15 days after receiving such notification from the *member*, we shall notify the *member* if a denial is issued for the *member's* request of transitional services based on the *member's physician* refusing to agree to accept our plan's reimbursement rates, adhere to the our plan's quality assurance requirements, provide our plan with necessary medical information related to the *member's* care, or otherwise adhere to our plan's policies and procedures. The notification shall be in writing and include the specific reason for such denial.

Services from Non- Network Providers
Except for emergency medical services and nonparticipating facility-based physician and provider, unless Covered Services are not available from Network Providers within a reasonable proximity such services will not be covered. If required Medically Necessary services are not available from Network Providers you or the Network Provider must request Prior Authorization from us before you may receive services from Non-Network Providers. Otherwise you will be responsible for all charges incurred.

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 for a *member* by 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.*

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 *contract'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,* except if required by state law.
4. For breast reduction or augmentation unless *medically necessary*.
5. For the reversal of sterilization and reversal of vasectomies.
6. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
7. For expenses for television, telephone, or expenses for other persons.
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
9. For telephone consultations or for failure to keep a scheduled appointment.
10. For stand-by availability of a *medical practitioner* when no treatment is rendered.
11. 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.
12. 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.
13. For diagnosis or treatment of learning disabilities, except if required by state law.
14. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
15. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
16. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
17. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
18. 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*. Coverage for eyeglasses is listed under Miscellaneous Outpatient Medical Services and Supplies Expense Benefits and Pediatric Vision Expense Benefits.

19. 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.
20. For treatment received outside the United States, except for a medical *emergency*.
21. As a result of:
    a. An *injury* or *illness* caused by any act of declared or undeclared war.
    b. The *member* taking part in a riot.
22. For or related to surrogate parenting.
23. For or related to treatment of hyperhidrosis (excessive sweating).
24. For fetal reduction surgery.
25. Except as specifically identified as a *covered service expense* under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
26. 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.
27. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); ; 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; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; transportation expenses, unless specifically described in this *contract*;
28. For court ordered testing or care unless Medically Necessary.
29. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a *member's* own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
30. Services or care provided or billed by a school, Custodial Care center for the developmentally disabled.

Exceptions to Limitations:

1. This *contract* will not deny *medically necessary* breast implant removal for a *sickness* or *injury.* However, this exception will not apply to the removal of breast implants that were done solely for cosmetic purposes.
2. This *contract* will not deny or exclude coverage for fibrocystic breast condition in the absence of a breast biopsy demonstrating an increased disposition to the development of breast cancer unless the *covered person's* medical history is able to confirm a chronic, relapsing, symptomatic breast condition.

TERMINATION

Termination Of Contract
All coverage will cease on termination of this *contract.* This *contract* will terminate on the earliest of:

1. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this contract (including, but not limited to, the Grace Period provision) or the date that we have not received timely premium payments in accordance with the terms of this contract; or
2. The date of termination that the Exchange provides us upon your request of cancelation; or
3. The date we decline to renew this Contract, as stated in the Discontinuance provision of this Contract; or
4. The date of your death; or
5. The date a *member's* eligibility for coverage under this Contract ceases as determined by the Exchange; or
6. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
7. The date the primary *member* no longer resides, lives or works in the Service Area of this plan.

Refund upon Cancellation
We will refund any premium paid and not earned due to *contract* termination. After the *contract* has been continued beyond its original term, *you* may cancel the *contract* at any time by written notice, delivered or mailed to the Marketplace, or if an off-exchange *member* by written notice, delivered or mailed to *us*. Such cancellation shall become effective upon receipt, or on such later date specified in the notice. If *you* cancel, *we* shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 days. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of the cancellation.

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* 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* 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. *You* must notify *us* of the address at which their continuation of coverage should be issued.

Benefits After Coverage Terminates
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 intentional 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.

Reinstatement

If any premium is not paid by the end of the grace period *your* coverage will terminate. Later acceptance of premium by *us*, within four calendar days of the end of the grace period, will reinstate *your contract* with no break in *your* coverage. *We* will refund any premium that *we* receive after this four-day period.

Reinstatement shall not change any provisions of the *contract.*

CLAIMS

Notice Of Claim
We must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible.

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* or *your* covered *dependent member had no legal capacity in that year.*

Time For Payment Of Claims
Benefits will be paid within 30 days after receipt of *proof of loss*. Should we determine that additional supporting documentation is required to establish responsibility of payment, we shall pay benefits within 30 days after receipt of *proof of loss*. If we do not pay within such period, we shall pay interest at the rate of 9 percent per annum from the 30th day after receipt of such proof of loss to the date of late payment.

Payment Of Claims
Except as set forth in this provision, all benefits are payable to *you.* Any accrued benefits unpaid at *your* death, or *your dependent member's* death may, at *our* option, be paid either to the beneficiary or to the estate. If any benefit is payable to *your* or *your dependent member's* estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, *we* may pay up to $1,000 to any relative who, in *our* opinion, is entitled to it.

We may pay all or any part of the benefits provided by this *contract* for *hospital,* surgical, nursing, or medical services, directly to the *hospital* or other person rendering such services.

Any payment made by *us* in good faith under this provision shall fully discharge *our* obligation to the extent of the payment. *We* reserve the right to deduct any overpayment made under this *contract* from any future benefits under this *contract*.

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.

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.

Post Stabilization Services
Timely determination shall mean a determination is made within 30 days after we receive a claim for post stabilization services if no additional information is needed to determine that services rendered were not contrary to our instructions. In the event additional information is necessary to make such a determination, we shall request the medical record documenting the time, phone number dialed, and the result of the communication for request for authorization of post stabilization medical services as well as the post stabilization medical services rendered within 15 days after receipt of the post stabilization services claim and make a determination within 30 days after its receipt.

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 three years after the date *proof of loss* is required.

No action at law or in equity may be brought against *us* under the *contract* for any reason unless the *member* first completes all the steps in the complaint/appeal procedures made available to resolve disputes in *your* state under the *contract.* After completing that complaint/appeal procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your* complaint/appeal.

Grievance Process
A grievance or complaint is an expression of dissatisfaction regarding our products or services. You or your designee may submit a grievance verbally or in writing. . You have up to 60 calendar days to file a Grievance. The 60 calendar days start on the date of the situation you are not satisfied with. Depending on the nature of the grievance and whether or not a response is requested, we will respond verbally and/or in writing within fifteen (15) business days following receipt of the grievance, or should a *member's* medical condition necessitate an expedited review a response within 24 hours.

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

INTERNAL CLAIMS AND APPEALS PROCEDURES AND EXTERNAL REVIEW

INTERNAL PROCEDURES

Applicability/Eligibility
The internal *grievance* procedures apply to any hospital or medical policy, *contract* or certificate or conversion plans, but not to accident only or disability only insurance.

An Eligible grievant is:
1. A *member;*
2. *P*erson authorized to act on behalf of the *member*. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format;

In the event the *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 *member* including any of the following:
1. Provision of services;
2. Determination to reform or rescind a contract;
3. Determination of a diagnosis or level of service required for evidence-based treatment of *autism spectrum disorders*; and
4. Claims practices.
5. is unable to give consent: a spouse, family member, or the treating *Provider*; or
6. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the *member*.

Important: *Adverse benefit determinations* that are not *grievances* will follow standard PPACA internal appeals processes.

Grievances
Members have the right to submit written comments, documents, records, and other information relating to the claim for benefits. *Member*s have the right to review the claim file and to present evidence and testimony as part of the internal review process. A *member* has a right to a 1st and 2nd level grievance and/or appeal review. The grievance and/or appeals can be sent to the following:

Ambetter Insured by Celtic
Attn.: Appeals and Grievances
999 Oakmont Plaza Drive, Suite 400
Westmont, IL 60559
Phone # 1-855-745-5507
TDD/TTY 1-866-565-8576
Fax # 1-877-668-2076
Email: gareferrals@centene.com

A *member* has the right to request an internal review in tandem with a provider's request for an expedited internal review or a concurrent review is in 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 *member* and the *member'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 *member* in writing with the appeal decision within the following timeframes:
    a. *Post-service claim*: within 15 business days after receipt of the member's request for internal appeal;
    b. *Pre-service claim*: within 15 business days after receipt of the *member's* request for internal appeal.

A *member* shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *member'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 *member* will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The plan will give the *member* 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 *member* will have the option of delaying the determination for a reasonable period of time to respond to the new information;
2. The *member* will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer. 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 three business days of receipt of a *grievance*, a written acknowledgment to the *member* or the *member*'s authorized representative confirming receipt of the *grievance* must be delivered or deposited in the mail.

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*; and
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 *grievance* panel will not include the person who made the initial determination and is not the subordinate of the original reviewer. The panel may, however, consult with the initial decision-maker. If the panel consists of at least three persons, the panel may then include no more than one subordinate of the person who made the initial determination.

The *grievance* panel will include:

1. At least one individual authorized to take corrective action on the *grievance*; and
2. At least one insured other than the grievant, if an insured is available to serve on the *grievance* panel. The *insured member* of the panel shall not be an employee of the plan, to the extent possible.

When the *adverse benefit determination* is based 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 *member* and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *member*'s health condition requires but not more than 24 hours after receipt of the *grievance*.

Due to the 24-hour resolution timeframe, the standard requirements for notification, *grievance* panel, and acknowledgement do not apply to *expedited grievances*.

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

Written Grievance 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; and
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 *member'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 *member'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 *member*;
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., customer service *complaints* - "the person to whom I spoke on the phone was rude to me";
    b. Providers with whom *we* have a contract;
        i. Lack of availability and/or accessibility of network providers not tied to an unresolved benefit denial; and
        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 *member* or the *member'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 State Insurance Department
The commissioner may require *us* to treat and process any *complaint* received by the State Insurance Department by, or on behalf of, a *member* as a *grievance* as appropriate. *We* will process the State Insurance Department *complaint* as a *grievance* when the commissioner provides *us* with a written description of the *complaint*.

External Review
An external review decision is binding on *us*. An external review decision is binding on the *member* 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.

If we have denied your request for the provision of or payment for a health care service or course of treatment, you have the right to have our decision reviewed by an independent review organization not associated with us.

Applicability/Eligibility
The G*rievance* procedures apply to:

1. Any hospital or medical policy, *contract* or certificate; excluding accident only or disability income only insurance; or
2. Conversion plans.

After exhausting the internal review process, the *member* has four months to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response.

1. The internal appeal process must be exhausted before the *member* may request an external review unless the *member* 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 *member* receives:
    a. An *adverse benefit determination* if the determination involves a medical condition of the *member* for which the timeframe for completion of an internal *expedited grievance* would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function and the *member* has filed a request for an internal *expedited grievance*; and
    b. A final internal *adverse benefit determination*, if the *member* 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 *member'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 *member* received emergency services, but has not been discharged from a facility; and
3. *Members* 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 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; or
2. *Rescissions* of coverage.

External Review Process
Request For External Review.
A *member* or the *member's* authorized representative may make a request for a standard external or expedited external review of an adverse determination or final adverse determination. Any pertinent additional information may be submitted with the request for standard or expedited external review.

Exhaustion of Internal Appeal Process.
For urgent situations, a *member* shall skip the internal appeal and standard review process and request an expedited external review.

A request for an external review shall not be made until the *member* has exhausted *our* internal appeal process. A *member* shall be considered to have exhausted *our* internal appeal process if:

- the *member* or the *member's* authorized representative has filed an appeal under *our* internal appeal process and has not received a written decision on the appeal 15 business days following the date the *member* or the *member 's* authorized representative files an appeal of an adverse determination that involves a concurrent or prospective review request or 15 business days following the date the

member or the *member's* authorized representative files an appeal of an adverse determination that involves a retrospective review request, except to the extent the *member* or the *member's* authorized representative requested or agreed to a delay;

- the *member* or the *member's* authorized representative filed a request for an expedited internal review of an adverse determination and has not received a decision on such request from *us* within 24 hours, except to the extent the *member* or the *member's* authorized representative requested or agreed to a delay;
- We agree to waive the exhaustion requirement;
- the *member* has a medical condition in which the timeframe for completion of (A) an expedited internal review of an appeal involving an adverse determination, (B) a final adverse determination, or (C) a standard external review would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function;
- an adverse determination concerns a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the *member's* health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated; in such cases, the *member* or the *member's* authorized representative may request an expedited external review at the same time the *member* or the *member's* authorized representative files a request for an expedited internal appeal involving an adverse determination; the independent review organization assigned to conduct the expedited external review shall determine whether the *member* is required to complete the expedited review of the appeal prior to conducting the expedited external review; or
- We have failed to comply with applicable State and federal law governing internal claims and appeals procedures.

Standard External Review

Within 4 months after the date of receipt of a notice of an adverse determination or final adverse determination, a *member* or the *member's* authorized representative may file a request for an external review with the Director. Within one business day after the date of receipt of a request for external review, the Director shall send a copy of the request to *us.* The addresses for the Director of Insurance follow:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 W. Washington Street
Springfield, IL 62767
(877) 850-4740 Toll-free phone
(217) 557-8495 Fax number
Doi.externalreview@illinois.gov
https://mc.insurance.illinois.gov/messagecenter.nsf

Within 5 business days following the date of receipt of the external review request, *we* shall complete a preliminary review of the request to determine whether:

- the individual is or was a *member* at the time the health care service was requested or at the time the health care service was provided;
- the health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the *member's* health benefit plan, but *we* have determined that the health care service is not covered;
- the *member* has exhausted our internal appeal process unless the *member* is not required to exhaust *our* internal appeal process pursuant to this Act; and
- the *member* has provided all the information and forms required to process an external review, as specified in this Act.

If the request:

- is not complete, *we* shall inform the Director and *member* and, if applicable, the *member's* authorized representative in writing and include in the notice what information or materials are required by this Act to make the request complete; or
- is not eligible for external review, *we* shall inform the Director and *member* and, if applicable, the *member's* authorized representative in writing and include in the notice the reasons for its ineligibility.

The notice of initial determination of ineligibility shall include a statement informing the *member* and, if applicable, the *member's* authorized representative that *our* initial determination that the external review request is ineligible for review may be objected to the Director by filing a complaint with Illinois Department of Insurance.

Notwithstanding *our* initial determination that the request is ineligible for external review, the Director may determine that a request is eligible for external review and require that it be referred for external review.
Whenever the Director receives notice that a request is eligible for external review following the preliminary review conducted, within one business day after the date of receipt of the notice, the Director shall:

- assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director and notify *us* of the name of the assigned independent review organization; and
- notify in writing the *member* and, if applicable, the *member's* authorized representative of the request's eligibility and acceptance for external review and the name of the independent review organization.

The Director shall include in the notice provided to the *member* and, if applicable, the *member's* authorized representative a statement that the *member* or the *member's* authorized representative may, within 5 business days following the date of receipt of the notice provided, submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after 5 business days.

The assignment by the Director of an approved independent review organization to conduct an external review shall be done on a random basis among those independent review organizations approved by the Director.

Within 5 business days after the date of receipt of the notice provided, *we* or *our* designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination; in such cases, the following provisions shall apply:

- Except as provided, failure by *us* or *our* utilization review organization to provide the documents and information within the specified time frame shall not delay the conduct of the external review.
- If *we* or *our* utilization review organization fails to provide the documents and information within the specified time frame, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
- Within one business day after making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination, the independent review organization shall notify the Director, *us*, the *member* and, if applicable, the *member's* authorized representative, of its decision to reverse the adverse determination.

Upon receipt of the information from *us* or *our* utilization review organization, the assigned independent review organization shall review all of the information and documents and any other information submitted in writing to the independent review organization by the *member* and the *member's* authorized representative.

Upon receipt of any information submitted by the *member* or the *member's* authorized representative, the independent review organization shall forward the information to *us* within 1 business day.

Upon receipt of the information, if any, *we* may reconsider its adverse determination or final adverse determination that is the subject of the external review.

Reconsideration by *us* of *our* adverse determination or final adverse determination shall not delay or terminate the external review.

The external review may only be terminated if *we* decide, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination. In such cases, the following provisions shall apply:

- Within one business day after making the decision to reverse its adverse determination or final adverse determination, *we* shall notify the Director, the *member* and, if applicable, the *member's* authorized representative, and the assigned independent review organization in writing of its decision.
- Upon notice from *us* that we have made a decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

In addition to the documents and information provided by us or *our* utilization review organization and the *member* and the *member's* authorized representative, if any, the independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

- the *member's* pertinent medical records;
- the *covered person's* health care provider's recommendation;
- consulting reports from appropriate health care providers and other documents submitted by *us* or *our* designee utilization review organization, the *membe*r, the *member's* authorized representative, or the covered person's treating provider;
- the terms of coverage under the *member's* health benefit plan with *us* to ensure that the independent review organization's decision is not contrary to the terms of coverage under the *member's* health benefit plan with the health carrier, unless the terms are inconsistent with applicable law;
- the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- any applicable clinical review criteria developed and used by *us* or *our* designee utilization review organization;
- the opinion of the independent review organization's clinical reviewer or reviewers after considering the above items to the extent the information or documents are available and the clinical reviewer or reviewers considers the information or documents appropriate.

Within 5 days after the date of receipt of all necessary information, but in no event more than 45 days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the Director, *us*, the *member*, and, if applicable, the *member's* authorized representative. In reaching a decision, the assigned independent review organization is not bound by any claim determinations reached prior to the submission of information to the independent review organization. In such cases, the following provisions shall apply:

The independent review organization shall include in the notice:

- a general description of the reason for the request for external review;
- the date the independent review organization received the assignment from the Director to conduct the external review;
- the time period during which the external review was conducted;

- references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision;
- the date of its decision;
- the principal reason or reasons for its decision, including what applicable, if any, evidence-based standards that were a basis for its decision; and
- the rationale for its decision.

Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, *we* immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

Expedited External review.
A *member* or a *member's* authorized representative may file a request for an expedited external review with the Director either orally or in writing:

- immediately after the date of receipt of a notice prior to a final adverse determination;
- immediately after the date of receipt of a notice upon final adverse; or
- if *we* fail to provide a decision on request for an expedited internal appeal within 48 hours as provided above.

Upon receipt of a request for an expedited external review, the Director shall immediately send a copy of the request to *us*. Immediately upon receipt of the request for an expedited external review *we* shall determine whether the request meets the reviewability requirements. In such cases, the following provisions shall apply:

- *We* shall immediately notify the Director, the *member's*, and, if applicable, the *member's* authorized representative of its eligibility determination.
- The notice of initial determination shall include a statement informing the *member's* and, if applicable, the *member's* authorized representative that a health carrier's initial determination that an external review request is ineligible for review may be objected to the Director by filing a complaint with the Illinois Department of Insurance.
- The Director may determine that a request is eligible for expedited external review notwithstanding *our* initial determination that the request is ineligible and require that it be referred for external review.
- In making a determination, the Director's decision shall be made in accordance with the terms of the covered person's health benefit plan, unless such terms are inconsistent with applicable law, and shall be subject to all applicable provisions of this provision.
- The Director may specify *our* notice of initial determination and any supporting information to be included in the notice.

Upon receipt of the notice that the request meets the reviewability requirements, the Director shall immediately assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director to conduct the expedited review. In such cases, the following provisions shall apply:

- Assignment of an approved independent review organization to conduct an external review in accordance with this Section shall be made from those approved independent review organizations qualified to conduct external review as required by Sections 50 and 55 of this Act.
- The Director shall immediately notify *us* of the name of the assigned independent review organization. Immediately upon receipt from the Director of the name of the independent review organization assigned to conduct the external review, but in no case more than 24 hours after receiving such notice, *we* or *our* designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

- If *we* or *our* utilization review organization fails to provide the documents and information within the specified timeframe, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
- Within one business day after making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination, the independent review organization shall notify the Director, *us*, the *member*, and, if applicable, the *member's* authorized representative of its decision to reverse the adverse determination or final adverse determination.

In addition to the documents and information provided by us or *our* utilization review organization and any documents and information provided by the *member* and the *member's* authorized representative, the independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider information in reaching a decision.

As expeditiously as the *member's* medical condition or circumstances requires, but in no event more than 72 hours after the date of receipt of the request for an expedited external review by the independent review organization, the assigned independent review organization shall:

- make a decision to uphold or reverse the final adverse determination; and
- notify the Director, *us*, the *member*, the *member's* health care provider, and, if applicable, the *member's* authorized representative, of the decision.

In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during our utilization review process or the health carrier's internal appeal process.

Upon receipt of notice of a decision reversing the adverse determination or final adverse determination, we shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

If the notice provided was not in writing, then within 48 hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the Director, we, the *member's*, and, if applicable, the *member's* authorized representative including the information as applicable.

An expedited external review may not be provided for retrospective adverse or final adverse determinations.

The assignment by the Director of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis among those independent review organizations approved by the Director.

External Review of Experimental or Investigational Treatment Adverse Determinations
Within 4 months after the date of receipt of a notice of an adverse determination or final adverse determination that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a *member* or the *member's* authorized representative may file a request for an external review with the Director.

The following provisions apply to cases concerning expedited external reviews:

- A *member* or the *member's* authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.
- Upon receipt of a request for an expedited external review, the Director shall immediately notify the health carrier.
- The following provisions apply concerning notice:

1. Upon notice of the request for an expedited external review, the health carrier shall immediately determine whether the request meets the reviewability requirements. *We* shall immediately notify the Director and the *member* and, if applicable, the *member's* authorized representative of its eligibility determination.
2. The Director may specify *our* notice of initial determination and any supporting information to be included in the notice. The notice of initial determination under shall include a statement informing the *member* and, if applicable, the *member's* authorized representative of *our* initial determination that the external review request is ineligible for review may be objected to the Director by filing a complaint with the Illinois Department of Insurance.

- The following provisions apply concerning the Director's determination:
  1. The Director may determine that a request is eligible for external review notwithstanding our initial determination that the request is ineligible and require that it be referred for external review.
  2. In making a determination, the Director's decision shall be made in accordance with the terms of the *member's* health benefit plan, unless such terms are inconsistent with applicable law.

Upon receipt of the notice that the expedited external review request meets the reviewability requirements, the Director shall immediately assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the Director and notify *us* of the name of the assigned independent review organization.

At the time *we* receive the notice of the assigned independent review organization, we or *our* designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

Except for a request for an expedited external review, within one business day after the date of receipt of a request for external review, the Director shall send a copy of the request to *us*.

Within 5 business days following the date of receipt of the external review request, *we* shall complete a preliminary review of the request to determine whether:

- the individual is or was a *member* in the health benefit plan at the time the health care service was recommended or requested or, in the case of a retrospective review, at the time the health care service was provided;
- the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination is a covered benefit under the *member's* health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the *member's* health benefit plan with *us*;
- the *member's* health care provider has certified that one of the following situations is applicable:
  1. standard health care services or treatments have not been effective in improving the condition of the *member*
  2. standard health care services or treatments are not medically appropriate for the *member's*; or
  3. there is no available standard health care service or treatment covered by *us* that is more beneficial than the recommended or requested health care service or treatment;
- the *member's* health care provider:
  1. has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the *member*, in the physician's opinion, than any available standard health care services or treatments; or
  2. who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the *member's* condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by

the *member* that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the *member* than any available standard health care services or treatments;

3. the *member* has exhausted our internal appeal process, unless the *member* is not required to exhaust the health carrier's internal appeal; and
4. the *member* has provided all the information and forms required to process an external review.

The following provisions apply concerning requests:

1. Within one business day after completion of the preliminary review, *we* shall notify the Director and *member* and, if applicable, the *member's* authorized representative in writing whether the request is complete and eligible for external review.
2. If the request:
   a) is not complete, then *we* shall inform the Director and the *member* and, if applicable, the *member's* authorized representative in writing and include in the notice what information or materials are required to make the request complete; or
   b) is not eligible for external review, then *we* shall inform the Director and the *member* and, if applicable, the *member's* authorized representative in writing and include in the notice the reasons for its ineligibility.
3. The Department may specify the form for *our* notice of initial determination and any supporting information to be included in the notice.
4. The notice of initial determination of ineligibility shall include a statement informing the *member* and, if applicable, the *member's* authorized representative that *our* initial determination that the external review request is ineligible for review may be object to the Director by filing a complaint with the Illinois Department of Insurance.
5. Notwithstanding *our* initial determination that the request is ineligible for external review, the Director may determine that a request is eligible for external review and require that it be referred for external review.

Whenever a request for external review is determined eligible for external review, we shall notify the Director and the *member* and, if applicable, the *member's* authorized representative.

Whenever the Director receives notice that a request is eligible for external review following the preliminary review conducted, within one business day after the date of receipt of the notice, the Director shall:

- assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director and notify *us* of the name of the assigned independent review organization; and
- notify in writing the *member* and, if applicable, the *member's* authorized representative of the request's eligibility and acceptance for external review and the name of the independent review organization.

The Director shall include in the notice provided to the *member* and, if applicable, the *member's* authorized representative a statement that the member or the *member's* authorized representative may, within 5 business days following the date of receipt of the notice provided, submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after 5 business days.

The following provisions apply concerning assignments and clinical reviews:

- Within one business day after the receipt of the notice of assignment to conduct the external review, the assigned independent review organization shall select one or more clinical reviewers, as it determines is appropriate, to conduct the external review.
- The provisions of this item apply concerning the selection of reviewers:
  1. In selecting clinical reviewers, the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications and, through clinical

experience in the past 3 years, are experts in the treatment of the *member's* condition and knowledgeable about the recommended or requested health care service or treatment.

2. Neither *we*, the *member* or *member's authorized representative* will *choose* or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

Each clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during *our* utilization review process or the health carrier's internal appeal process.

Within 5 business days after the date of receipt of the notice provided, *we* or *our* designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination; in such cases, the following provisions shall apply:

- failure by *us* or *our* utilization review organization to provide the documents and information within the specified time frame shall not delay the conduct of the external review.
- If *we* or *our* utilization review organization fails to provide the documents and information within the specified time frame, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
- Immediately upon making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination, the independent review organization shall notify the Director, *us*, the *member*, and, if applicable, the *member's* authorized representative of its decision to reverse the adverse determination.

Upon receipt of the information from *us* or *our* utilization review organization, each clinical reviewer selected shall review all of the information and documents and any other information submitted in writing to the independent review organization by the *member* and the *member's* authorized representative.

Upon receipt of any information submitted by the *member* or the *member's* authorized representative, the independent review organization shall forward the information to *us* within one business day. In such cases, the following provisions shall apply:

- Upon receipt of the information, if any, *we* may reconsider its adverse determination or final adverse determination that is the subject of the external review.
- Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review.
- The external review may be terminated only if *we* decide, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination. In such cases, the following provisions shall apply:
    1. Immediately upon making its decision to reverse its adverse determination or final adverse determination, *we* shall notify the Director, the *member* and, if applicable, the *member's* authorized representative, and the assigned independent review organization in writing of its decision.
    2. Upon notice from the health carrier that *we* have made a decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

The following provisions apply concerning clinical review opinions:

- within 45 days after being selected, each clinical reviewer shall provide an opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

- Except for an opinion, each clinical reviewer's opinion shall be in writing and include the following information:
  1. a description of the *member's* medical condition;
  2. a description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the *member* than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;
  3. a description and analysis of any medical or scientific evidence considered in reaching the opinion;
  4. a description and analysis of any evidence-based standard; and
  5. information on whether the reviewer's rationale for the opinion is based on.

The provisions of this item (3) apply concerning the timing of opinions:

For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the *member's* medical condition or circumstances requires, but in no event more than 5 calendar days after being selected.

If the opinion provided was not in writing, then within 48 hours following the date the opinion was provided, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required.

In addition to the documents and information provided by *us* or *our* utilization review organization and the *member* and the *member's* authorized representative, if any, each clinical reviewer selected, to the extent the information or documents are available and the clinical reviewer considers appropriate, shall consider the following in reaching a decision:

- the *member's* pertinent medical records;
- the *member's* health care provider's recommendation;
- consulting reports from appropriate health care providers and other documents submitted by *us* or our designee utilization review organization, the *member*, the *member's* authorized representative, or the *member's* treating physician or health care professional;
- the terms of coverage under the *member's* health benefit plan with *us* to ensure that, but for *our* determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the *member's* health benefit plan with *us* and
- whether the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition or medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the *member* than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

The following provisions apply concerning decisions, notices, and recommendations:

- The provisions of this item apply concerning decisions and notices:
  1. Except as provided, within 45 days after the date it receives the opinion of each clinical reviewer, the assigned independent review organization, shall make a decision and provide written notice of the decision to the Director, *us*, the *member*, and the *member's* authorized representative, if applicable.
  2. For an expedited external review, within 72 hours after the date it receives the opinion of each clinical reviewer, the assigned independent review organization, shall make a decision and provide notice of the decision orally or in writing to the Director, *us*, the *member*, and the *member's*

authorized representative, if applicable. If such notice is not in writing, within 72 hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the Director, *us*, the *member*, and the *member's* authorized representative, if applicable. The independent review organization has 5 days to provide notice of the decision for expedited experimental reviews.

If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, then the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.

If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.

These provisions apply to cases in which the clinical reviewers are evenly split:

- If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, then the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers.
- The additional clinical reviewer selected shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions.
- The selection of the additional clinical reviewer shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers.

The independent review organization shall include in the notice provided:

- a general description of the reason for the request for external review;
- the written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
- the date the independent review organization received the assignment from the Director to conduct the external review;
- the time period during which the external review was conducted;
- the date of its decision;
- the principal reason or reasons for its decision; and
- the rationale for its decision.

Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, *we* shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

The assignment by the Director of an approved independent review organization to conduct an external review shall be done on a random basis among those independent review organizations approved by the Director.

Binding Nature of External Review Decision

An external review decision is binding on *us*. An external review decision is binding on the covered person except to the extent the *member* has other remedies available under applicable federal or State law. A *member* or the *member's* authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the *member* has already received an external review.

If a *member* has a change in medical status for a treatment or procedure not previously approved, the *member*

may become eligible for a subsequent external review.

Disclosure Requirements
We shall include a description of the external review procedures in, or attached to, the *contract*, and outline of coverage or other evidence of coverage it provides to *members*.

The description required shall include a statement that informs the covered person of the right of the *member* to file a request for an external review of an adverse determination or final adverse determination with the Director. The statement shall explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness. The statement shall include the toll-free telephone number and address of the Office of Consumer Health Insurance within the Department of Insurance.

GENERAL PROVISIONS

Entire Contract
This *contract,* with the application*, S*chedule of Benefits 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 intentional 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 intentional misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *member.* A *member's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

Repayment For Fraud, Intentional Misrepresentation Or False Information
During the first two years a *member* is covered under the *contract*, if a *member* commits fraud, intentional misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *contract* or in filing a claim for *contract* benefits, *we* have the right to demand that *member* pay back to *us* all benefits that *we* provided or paid during the time the *member* was covered under the *contract*.

Conformity With 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.

Statement of Non-Discrimination

Ambetter Insured by Celtic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter Insured by Celtic does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter Insured by Celtic:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Ambetter Insured by Celtic at 1-855-745-5507 (TTY/TDD 1-866-565-8576).

If you believe that Ambetter Insured by Celtic has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Complaints and Grievance Coordinator, 999 Oakmont Plaza Drive, Suite 400, Westmont, IL 60559, 1-855-745-5507 (TTY/TDD 1-866-565-8576), Fax 1-855-519-5699. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter Insured by Celtic is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter Insured by Celtic, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-745-5507 (TTY/TDD 1-866-565-8576).
Polish:	Jeżeli ty lub osoba, której pomagasz, macie pytania na temat Ambetter Insured by Celtic, macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-855-745-5507 (TTY/TDD 1-866-565-8576).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter Insured by Celtic 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-855-745-5507 (TTY/TDD 1-866-565-8576)。
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter Insured by Celtic 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-745-5507 (TTY/TDD 1-866-565-8576) 로 전화하십시오.
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter Insured by Celtic, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-855-745-5507 (TTY/TDD 1-866-565-8576).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter Insured by Celtic، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-855-745-5507 (TTY/TDD 1-866-565-8576).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter Insured by Celtic вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-855-745-5507 (TTY/TDD 1-866-565-8576).
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter Insured by Celtic વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-855-745-5507 (TTY/TDD 1-866-565-8576) ઉપર કોલ કરો.
Urdu:	اگر Ambetter Insured by Celtic کے بارے میں آپ، یا جن کی آپ مدد کررہے ہیں ان کے سوالات ہوں تو، آپ کو بلامعاوضہ اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے، 1-855-745-5507 (TTY/TDD 1-866-565-8576) پر کال کریں۔
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter Insured by Celtic, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-745-5507 (TTY/TDD 1-866-565-8576).
Italian:	Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter Insured by Celtic, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'1-855-745-5507 (TTY/TDD 1-866-565-8576).
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter Insured by Celtic के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-855-745-5507 (TTY/TDD 1-866-565-8576) पर कॉल करें।
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter Insured by Celtic, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-855-745-5507 (TTY/TDD 1-866-565-8576).
Greek:	Εάν εσείς ή κάποιος που βοηθάτε, έχετε ερωτήσεις σχετικά με την Ambetter Insured by Celtic, έχετε το δικαίωμα να ζητήσετε βοήθεια και πληροφορίες στη γλώσσα σας, χωρίς χρέωση. Για να μιλήσετε με διερμηνέα, καλέστε το 1-855-745-5507 (TTY/TDD 1-866-565-8576).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter Insured by Celtic hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-745-5507 (TTY/TDD 1-866-565-8576) an.