



FROM |  buckeye
health plan.

2017 Evidence of Coverage



Ambetter Individual Health Benefit Plan
Issued and underwritten by Buckeye Health Plan
Home Office: 4349 Easton Way, Suite 400, Columbus, OH, 43219

Individual Member Contract

In this *policy*, “*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 Buckeye Health Plan.

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 *loss* due to *illness* or *bodily injury* 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 as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all contracts issued on this form, with the same type and level of benefits, to residents of the state where *you* then live; or (2) *we* withdraw from the service area or reach demonstrated capacity in a service area in whole or in part; (3) there is fraud or a 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.

As a cost containment feature, this *contract* contains prior authorization requirements. This contract may require a referral from a primary care provider 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.

This policy is not a Medicare supplement policy. If you are eligible for Medicare, review the “Guide to Health Insurance for People with Medicare” available from the company.

COORDINATION OF BENEFITS

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

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*.

Buckeye Health Plan

A handwritten signature in black ink, appearing to read "Bruce Hill", is centered within a light gray rectangular box.

Bruce Hill, CEO and Plan President

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INTRODUCTION

Welcome to Ambetter from Buckeye Health Plan! 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 healthcare 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.

How To Contact Us

Ambetter from Buckeye Health Plan
4349 Easton Way, Suite 400
Columbus, OH, 43219

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST, Monday through Friday

Member Services **1-877-687-1189**

TDD/TTY line **1-877-941-9236**

Fax **1-877-941-8076**

Emergency **911**

24/7 Nurse Advice Line **1-877-687-1189**

Interpreter Services

Ambetter from Buckeye Health Plan has a free service to help our *members* who speak languages other than English. This service is very important because *you* and your *provider* 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 1-877-687-1189 (TDD/TTY 1-877-941-9236).

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 healthcare 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* healthcare. 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 provider* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care provider* 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 provider* will ask for your approval for treatment unless there is an *emergency medical condition* 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 provider(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 provider* 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; and
 - 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*. A listing of *network providers* is available online at

Ambetter.BuckeyeHealthPlan.com. You can find any of our *network providers* by visiting our website and using the “Find a Provider” function. *You* can also get information on *your network providers’* education, training, and practice.

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 emergency services* 24 hours a day and seven days a week.
18. Access *medically necessary urgent care* through *network providers* 24 hours a day and seven days a week, including our 24/7 Nurse Advice Line.
19. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
20. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care provider’s* instructions are not followed. *You* should discuss all concerns about treatment with your *primary care provider*. Your *primary care provider* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
21. Select *your primary care provider* within the *network*. *You* also have the right to change your *primary care provider* or request information on *network providers* close to your home or work.
22. Know the name and job title of people giving you care. *You* also have the right to know which *provider* is your *primary care provider*.
23. An interpreter when *you* do not speak or understand the language of the area.
24. A second opinion by a *network provider* if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
25. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
26. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help your *primary care provider* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
 - a. Living Will;
 - b. Health Care Power of Attorney; or
 - 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 healthcare 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 *provider* 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 provider*, and call the *provider’s* office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care provider*. *You* should establish a relationship with *your provider*. *You* may change your *primary care provider* 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* healthcare professionals and *providers* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* healthcare professionals and *providers* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* healthcare professionals and *providers*.
11. Tell *your* healthcare professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care provider* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
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 provider*.
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*. Please call Member Services at 1-877-687-1189.

Continuity of Care

If *your* provider is terminated without cause from our network, *you* have the right to continue with an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter.

Your Provider Directory

A listing of *network providers* is available online at Ambetter.BuckeyeHealthPlan.com. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* healthcare services. You can find any of our *network providers* by visiting our website and using the "Find a Provider" function. 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 printed copy of the provider directory at no charge by calling Member Services at 1-877-687-1189. In order to obtain benefits, *you* must designate a *network primary care provider* for each *member*. *We* can also help *you* pick a *primary care provider* (PCP). *We* can make your choice of *primary care provider* effective on the next business day.

Call the *providers* office if you want to make an appointment. If *you* need help, call Member Services at 1-877-687-1189. *We* will help *you* make the appointment.

Your Member ID Card

When *you* enroll, *we* will mail you a member ID card within 5 business days of *our* receipt of *your* completed enrollment materials, which includes receipt of your initial binder payment. This card is proof that *you* are

enrolled in a Buckeye Health Plan 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 any *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 1-877-687-1189, 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.BuckeyeHealthPlan.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 online member account for *you* to check the status of *your* claims.
4. Online form submission.
5. Our programs and services.
6. The quarterly newsletter.
7. Current events and news with your Ambetter plan.
8. Deductible and Copayment Accumulators.
9. Making your payment.

You may also access the Federal Government's website at 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 *providers* 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 provider* or service provided by *us*, please contact the Member Services Department at **1-877-687-1189**.

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*.

Advanced premium tax credit means payment of the tax credits specified in section 36B of the Code (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a *QHP* through an Health Insurance Marketplace in accordance with sections 1402 and 1412 of the Affordable Care Act.

Affordable Care Act “ACA” means the comprehensive healthcare 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.

Autism spectrum disorder means autism spectrum disorder as defined by the most recent editions 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.

Cardiac rehabilitation means to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

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 provider*.

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*.

Chemotherapy means the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.

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*.

Complaint means any expression of dissatisfaction expressed to the insurer by the claimant, or a claimant's authorized representative, about an insurer or its providers with whom the insurer has a direct or indirect contract.

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, provider 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 Indian 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 *provider*. 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. For family coverage, the family deductible amount can be met with the combination of any one or more covered persons' *eligible service expenses*.

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

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

Dependent member means *your spouse* and/or an *eligible child*.

Diagnostic services means tests or procedures performed when you have specific symptoms, to detect or monitor your condition.

1. X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
2. Magnetic Resonance Angiography (MRA).
3. Magnetic Resonance Imaging (MRI).
4. CAT scans.
5. Laboratory and pathology services.
6. Cardiographic, encephalographic, and radioisotope tests.
7. Nuclear cardiology imaging studies.
8. Ultrasound services.
9. Allergy tests.
10. Electrocardiograms (EKG).
11. Electromyograms (EMG) except that surface EMG's are not Covered Services.
12. Echocardiograms.
13. Bone density studies.
14. Positron emission tomography (PET scanning).
15. Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
16. Echographies.
17. Doppler studies.
18. Brainstem evoked potentials (BAER).
19. Somatosensory evoked potentials (SSEP).
20. Visual evoked potentials (VEP).
21. Nerve conduction studies.
22. Muscle testing.

23. Electrocorticograms.
24. Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a hospital or provider's office.

Dialysis treatments means treatment of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

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 *illness* or *injury*.

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:
 - a. Tests how to administer a healthcare service, item, or drug for the treatment of cancer;
 - b. Tests responses to a healthcare service, item, or drug for the treatment of cancer;
 - c. Compares the effectiveness of a healthcare service, item, or drug for the treatment of cancer with that of other healthcare services, items, or drugs for the treatment of cancer; or
 - d. Studies new uses of a healthcare service, item, or drug for the treatment of cancer.
- e) The trial is approved by one of the following entities:
 - a. The National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
 - b. The United States Food and Drug Administration;
 - c. The United States Department of Defense; or
 - d. The United States Department of Veterans' Affairs.
- f) A medical professional has determined the cancer clinical trial is appropriate for the *enrollee*.

Eligible child means *your* or *your spouse's* child, 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; or
5. A child for whom legal guardianship has been awarded to *you* or *your spouse*. It is *your* responsibility to notify *us* if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* provide or pay for a child at a time when the child did not qualify as an *eligible child*.

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

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible service expense* is the contracted fee with that provider.
2. For *non-network providers*:
 - a. When a *covered service* is received from a *non-network provider* as a result of an emergency, the eligible service expense is the lesser of (1) the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full (you will not be billed for the difference between the negotiated fee and the provider's charge), or (2) the provider's billed charge. In either circumstance, *you* will not be billed for the difference between the negotiated or accepted fee, as applicable, and the provider's charge.

- b. When a *covered service* is received from a *non-network provider* and there is not an appropriate *network provider* available to render the *covered service*, the *eligible service expense* is the lesser of (1) the negotiated fee, if any, that has been mutually agreed upon by *us* and the provider as payment in full, or (2) the amount accepted by the provider (not to exceed the provider's billed charge). In either circumstance, *you* will not be billed for the difference between the negotiated or accepted fee, as applicable, and the provider's charge. You must receive pre-authorization or approval from *us*, prior to receiving the service.

Essential Health Benefits provided within this Certificate 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. Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories: Ambulatory patient services, Emergency services, Hospitalization, Maternity and newborn care, Mental health and substance use disorder services, including behavioral health treatment, Prescription drugs, Rehabilitative and habilitative services and devices, Laboratory services, Preventive and wellness services, and chronic disease management and pediatric services, including oral and vision care.

Emergency medical condition means a medical condition manifesting itself by such acute symptoms of sufficient severity (including 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.

Emergency services means the following:

1. A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition;
2. Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

Experimental or investigational treatment means medical, surgical, diagnostic, or other healthcare 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 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 abuse, custodial care, nursing care, or for care of mental disorders* or the mentally incompetent.

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

If no credible scientific evidence is available, then standards 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 healthcare service, supply, or drug is *medically necessary* and is a *covered service* under the *policy*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

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

1. Quality of care;
2. Provider behavior;
3. Waiting times for services; or
4. Involuntary disenrollment.

Habilitation means *medically necessary* habilitative services and devices which are health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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.

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

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

Inhalation therapy means the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

In-network means services provided by a *network provider* (or *preferred provider*).

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 services means that services, supplies, or treatment, for medical, behavioral health and substance abuse, 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. This includes:

1. Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.

2. Ancillary (related) services.
3. Professional services from a provider while an Inpatient.

Room, Board, and General Nursing Services include:

1. A room with two or more beds.
2. A private room. The private room allowance is the Hospital's average semi-private room rate unless it is *medically necessary* that you use a private room for isolation and no isolation facilities are available.
3. A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services include:

1. Operating, delivery and treatment rooms and equipment.
2. Prescribed Drugs.
3. Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
4. Medical and surgical dressings, supplies, casts and splints.
5. Diagnostic Services.
6. Therapy Services.

Professional Services include:

1. Medical care visits limited to one visit per day by any one Physician.
2. Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time.
3. Concurrent care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
4. Consultation which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
5. Surgery and the administration of general anesthesia.
6. Newborn exam. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

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.

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).

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

Manipulation Therapy includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

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, Buckeye Health Plan 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*.

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 means, but is not limited to, a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. 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. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy*: 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.

Medically necessary means any medical service, supply or treatment authorized by a *provider* 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 *provider* 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 *you, your spouse* and each *eligible child*:

1. Named in the application; or
2. Whom we agree in writing to add as a *member*.

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.

Network means a group of *physicians* and *providers* who have contracts that include an agreed upon price for healthcare 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 (or **preferred provider**) means a *physician* or *provider* who is identified in the most current list for the *network* shown on *your* identification card. Services received from a *network provider* are “in-network”.

Non-elective caesarean section means:

1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

Non-network eligible service expense means the *eligible service expense* for services or supplies that are provided and billed by a *non-network provider*.

Non-Network Provider (or **non-preferred 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 “out-of-network” and are not covered, except as specifically stated in this policy.

Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person’s ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person’s particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

Oral chemotherapy means the treatment with drugs given by mouth to kill cancer cells or stop them from dividing.

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 services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by us. Professional charges only include services billed by a Physician or other professional.

Outpatient surgical facility (or **ambulatory surgery centers**) 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.

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 healthcare system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

Physical therapy including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.

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." This also includes over-the-counter drugs prescribed by a *provider*.

Prescription drug deductible amount means the amount of *covered expenses*, shown in the Schedule of Benefits, if applicable, that must actually be paid during any calendar year before any *prescription drug* benefits

are payable. The family *prescription drug deductible amount* is two times the individual *prescription drug deductible amount*. For family coverage, once a *covered person* has met the individual *prescription drug deductible amount*, any remaining family *prescription drug deductible amount* can be met with the combination of any one or more covered persons' *eligible service expenses*.

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

Primary care provider means a *provider* 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.

Provider facility means a *hospital*, *rehabilitation facility*, or *extended care facility*.

Pulmonary rehabilitation means to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

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.

Radiation therapy means the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

Reconstructive surgery means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including surgery after a mastectomy, 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*.

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 policy means a cancellation or discontinuance of coverage that has a retroactive effect. Rescission does not include a cancellation or discontinuance of 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, including those for treatment of mental health and substance use disorders, 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 Ohio 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 healthcare services and supplies. You can receive precise service area boundaries from our website or our Member Services department.

Skilled Nursing Facility means a provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
2. provides care supervised by a Physician;
3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
5. is not a rest, educational, or custodial Provider or similar place.

Specialist provider means a *physician* who is not a *primary care provider*. A *specialist provider* focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. Examples of specialists include cardiologists, dermatologists, and gynecologists.

Speech therapy for the correction of a speech impairment.

Spouse means *your* lawful wife or husband.

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

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

Surgery or **surgical procedure** means:

1. An invasive diagnostic procedure; or

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

Surveillance tests for ovarian cancer means annual screening using:

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

Terminal illness counseling means counseling of the *immediate family* of a *terminally ill* person for the purpose of teaching the *immediate family* to care for and adjust to the *illness* and impending death of the *terminally ill* person.

Terminally ill means a *physician* has given a prognosis that a *member* has six months or less to live.

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

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

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

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

Urgent care center means a facility, not including a *hospital emergency room* or a *physician's office*, that provides treatment or services that are required:

1. To prevent serious deterioration of a *member's* health; 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, healthcare 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 first day of the premium period/first full calendar month after the date of becoming *your dependent*.

Effective Date for Initial Dependent Members

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

Adding 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. If notice of the newborn is given to *us* by the Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. 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 and the required premium is received.

Adding 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 and where the issuer is notified by the Marketplace. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both: (A) Notification of the addition of the child from the Marketplace within 60 days of the birth or placement and (B) any additional premium required for the addition of the child within 90 days of the date of *placement*.

As used in this provision, "*placement*" 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.

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 Covered Persons

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

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

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*. For *eligible children*, the coverage will terminate the thirty-first of December the year the dependent turns 28 years of age.

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

Out of Service Area Dependent Member Coverage

A *dependent member's* coverage will not cease should the *dependent member* live outside the service area if a court order requires the *member* to cover such *dependent member*.

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 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 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 enroll as a result of one of the following events:

1. A *qualified individual* or *dependent* loses minimum essential coverage;
2. A *qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption or placement for adoption;
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual who is released from incarceration;

5. A *qualified individual's* enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
6. 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;
7. An individual is determined newly eligible or newly ineligible for *advanced premium tax credit* or has a change in eligibility for *cost-sharing reductions*, regardless of whether such individual is already enrolled in a *qualified health plan*;
8. A *qualified individual* or enrollee gains access to new *qualified health plans* as a result of a permanent move;
9. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended:
 - a. The qualifying events for employees are:
 - i. Voluntary or involuntary termination of employment for reasons other than gross misconduct; or
 - ii. Reduction in the number of hours of employment.
 - b. The qualifying events for spouses are:
 - i. Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
 - ii. Reduction in the hours worked by the covered employee;
 - iii. Covered employee's becoming entitled to Medicare;
 - iv. Divorce or legal separation of the covered employee; or
 - v. Death of the covered employee.
 - c. The qualifying events for dependent children are the same as for the spouse with one addition:
 - i. Loss of dependent child status under the plan rules.
10. 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
11. 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

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 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 premium tax credit* and *cost-sharing reduction* payments until the first of the next month.

Loss of Minimum Essential Coverage

Loss of Minimum Essential Coverage 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 an individual incurs a claim that would meet or exceed a lifetime limit on all benefits;
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual;
6. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent; and
7. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

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 month during 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 month of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. *We* will notify HHS of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. *We* will continue to collect *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 one (1) month grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force; 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.

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 *us* of *your* new *residence* within 60 days of the change. *Your* premium will be based on *your* new *residence* beginning on the first premium due date/first day of the next calendar month after the change. If *your residence* is misstated on *your* application, or *you* fail to notify *us* of a change of *residence*, *we* will apply the correct premium amount beginning on the first premium due date/first day of the first full calendar month *you* resided at that place of *residence*. If the change results in a lower premium, *we* will refund any excess premium. If the change results in a higher premium, *you* will owe *us* the additional premium.

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 amount* does not include any *copayment amount*.

Cost Sharing Percentage

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

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

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

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

The amount provided or payable will be subject to:

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

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

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

Primary Care Provider

In order to obtain benefits, *you* must designate a *network primary care provider* for each *member*. *You* may select any *network primary care provider* who is accepting new patients. For children, *you* may designate a pediatrician as a *network primary care provider*. Women may designate an OB/GYN as a *network primary care provider*. However, *you* may not change your selection more frequently than once each month. If *you* do not select a *network primary care provider* for each *member*, one will be assigned. *You* may obtain a list of *network primary care providers* at our website or by calling the telephone number shown on the front page of this *contract*.

Your network primary care provider 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 provider* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist.

You may change *your network primary care provider* 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 provider* of record will be effective no later than 30 days from the date we receive *your* request.

Referral Required For Maximum Benefits

You do not need a referral from *your network primary care provider* for obstetrical or gynecological treatment from a *network obstetrician or gynecologist*. For all other *network specialist providers*, you may be required to obtain a referral from *your network primary care provider* for benefits to be payable under *your policy* or benefits payable under this *contract* will be reduced.

Service Area

Ambetter operates in a limited service area. If the subscriber moves from one county to another within the service area, the monthly premiums may be increased or changed. If the subscriber moves from one county in the service area to another that is not in the service area, you will no longer be eligible for coverage under this contract, and will be eligible for special enrollment into another *qualified health plan*.

Coverage Under Other Policy Provisions

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

Emergency Services

If you are experiencing an emergency, call 9-1-1 or go to a hospital. Emergency services do not require prior authorization.

Emergency services are available at hospitals that are *network providers*. If you are unable to get to a *network provider*, you also may obtain emergency services from a hospital that is a *non-network provider*.

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

Urgent Care

Urgent Care includes *medically necessary services*, including facility costs and supplies, or care for a condition that is not an emergency, but is an unforeseen medical illness, injury or condition that requires immediate care when the *member's primary care provider* is unavailable or inaccessible. Urgent Care is covered at network hospitals, *Urgent Care Centers*, or *Network Providers'* offices. Urgent care received at any hospital emergency department is not covered unless authorized in advance by us.

Urgent Care is not covered for services received by a *non-network provider* or at an out-of-network facility.

Members are encouraged to contact their *Primary Care Provider* for an appointment before seeking care from another Provider. If the *Primary Care Provider* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-877-687-1189. The 24/7 Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week. A Registered Nurse can help you decide the kind of care most appropriate for your specific need.

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.

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.

Accidental Dental

Coverage will be provided for *dental service expenses* when a *member* suffers an *injury*, after the *member's effective date* of coverage, that results in:

1. Damage to his or her natural teeth; and
2. Expenses are incurred within twelve months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within twelve months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.

Treatment for accidental dental is limited to \$3,000 per occurrence.

Contraception

All FDA-approved contraception methods (identified on www.fda.gov) 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. For further detail, please see the definition of "Family Planning Services," below.

Chiropractic Services

We cover charges for chiropractic 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 *medical practitioner*.

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 is also included for *eligible cancer clinical trials*. 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 insured's who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

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

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

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

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

Benefits for an *eligible cancer clinical trial* do not, however, include the following:

- a) A health care service, item, or drug that is the subject of the cancer clinical trial or is provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- b) An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration;
- c) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
- d) An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; or
- e) A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

Diabetic Care

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

Covered service expenses also include all Provider prescribed *medically necessary* equipment and supplies used for the management and treatment of diabetes. See "Durable Medical Equipment and Covered Medical Supply Expense Benefits" and "Preventive Care Expense Services" "Physician Home Visits and Office Services". Screenings for gestational diabetes are covered under "Preventive Care Expense Services."

Durable Medical Equipment, Prosthetics, Orthotic Devices, and Covered Medical Supply Expense Benefits

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

- The equipment, supply or appliance is a Covered Service;
- The continued use of the item is *medically necessary*; and
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

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

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

Benefits for repairs and replacement do not include the following:

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

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

Medical and surgical supplies

Certain supplies and equipment for the management of disease that we approve are covered under the Prescription Drug benefit.

Covered Services may include, but are not limited to:

1. Allergy serum extracts.
2. Chem strips, Glucometer, Lancets.
3. Clinitest.
4. Needles/syringes.
5. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Exclusions:

Non Covered Services include but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators.
2. Arch supports.
3. Doughnut cushions.
4. Hot packs, ice bags.
5. Vitamins (except as provided for under Preventive benefits).
6. Medijectors.
7. Items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Durable medical equipment

The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be

rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for IV fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal and sleep apnea monitors.
8. Augmentive communication devices are covered when We approve based on the Member's condition.

Exclusions:

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

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

Prosthetics

Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

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

Prosthetic devices should be purchased not rented, and must be *medically necessary*. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is

performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.

6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).

Exclusions:

Non-covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Artificial heart implants.
5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury.

Orthotic devices

Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Covered orthotic devices may include, but are not limited to, the following:

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.

Orthotic appliances may be replaced once per year per Member when *medically necessary* in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

Exclusions:

Non-covered services include but are not limited to:

1. Orthopedic shoes (except therapeutic shoes for diabetics).
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
4. Garter belts or similar devices.

Family Planning Services

Covered service expenses for Family Planning include:

1. Medical history review.
2. Physical examinations.
3. Laboratory tests related to physical examinations.
4. Contraceptive counseling.
5. All FDA-approved contraception methods are covered without cost sharing as outlined at www.fda.gov (see “Contraception” section above). This benefit contains both pharmaceutical and medical methods, including but not limited to:
 - a. Intrauterine devices (IUD), including insertion and removal;
 - b. 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;
 - c. Oral contraceptives including the pill (combined pill and extended/continuous use), and the mini pill (Progestin only), patch;
 - d. Other hormonal contraceptives, including inserted and implanted contraceptive devices, hormone contraceptive injections and the vaginal contraceptive ring; and
 - e. Emergency contraception (the morning after pill).
6. FDA-approved tubal ligation.
7. Vasectomy and services related to this procedure.
8. For Prescription Drug contraceptives.

Home Health Care Service Expense Benefits

Covered service expenses for *home health care* include, but are not limited to, the following charges:

1. Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
2. Medical/Social Services.
3. Diagnostic Services.
4. Nutritional Guidance.
5. Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
6. Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
7. Medical/Surgical Supplies.
8. Durable Medical Equipment.
9. Prescription Drugs (only if provided and billed by a Home Health Care Agency).
10. Private Duty Nursing.

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. If the equipment is purchased, the *member* must return the equipment to *us* when it is no longer in use.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment, and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, and continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Exclusions and Limitations:

No benefits will be payable for charges related to *respite care*, *custodial care*, or educational care, under the Home Health Care Service Expense benefit. Non Covered Services include but are not limited to:

1. Food, housing, homemaker services and home delivered meals.

2. Home or Outpatient hemodialysis services (these are covered under Therapy Services).
3. Physician charges.
4. Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices).
5. Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
6. Services provided by a member of the patient's immediate family.
7. Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside.

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

Hospice Care Service Expense Benefits

Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician. Covered Services will continue if the Member lives longer than six months.

When approved by your Physician, Covered Services include the following:

- Skilled Nursing Services (by an R.N. or L.P.N.).
- Diagnostic Services.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances (benefits will not be covered for equipment when the Member is in a Facility that should provide such equipment).
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide.

Non Covered Services include but are not limited to:

- Services provided by volunteers.
- Housekeeping services.

Infertility

Covered service expenses under this benefit are provided for *medically necessary diagnostic services* and exploratory procedures to determine infertility including surgical procedures to correct a medically diagnosed disease or condition of the reproductive organs including but not limited to treatment of the following:

- Endometriosis;
- Collapsed/clogged fallopian tubes; or
- Testicular failure.

This benefit is subject to deductible and coinsurance/copayment.

No benefits will be payable for charges related to in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT).

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.

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

Maternity Coverage

Maternity coverage include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, therapeutic abortion (abortion recommended by a Provider), and ordinary routine nursery care for a healthy newborn. Abortion means the ending of a pregnancy before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the mother, or as a result of incest or rape.

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

When a decision is made to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within seventy-two hours after discharge.

Physician-directed follow-up care after delivery is also covered. Services covered as follow-up care include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any *medically necessary* and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage applies to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if you're attending Physician determines further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
 1. the antepartum, intrapartum, and postpartum course of the mother and infant;
 2. the gestational stage, birth weight, and clinical condition of the infant;
 3. the demonstrated ability of the mother to care for the infant after discharge; and
 4. the availability of postdischarge follow-up to verify the condition of the infant after discharge.

Covered Services include at-home post delivery care visits at your residence by a Physician or Nurse performed no later than 72 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

1. parent education;
2. assistance and training in breast or bottle feeding; and
3. performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office.

Newborns' And Mothers' Health Protection Act Statement Of Rights

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

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 healthcare 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.

Mental Health and Substance Use Disorder Benefits

Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter. Mental health services will be provided on an inpatient and outpatient basis and include treatable mental disorders. These disorders affect the member's ability to cope with the requirements of daily living. If you need mental health and/or substance use disorder treatment, you may choose any provider participating in 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 service expenses* only when billed as a supporting diagnosis.

When making coverage determinations, Cenpatico utilizes established level of care guidelines and medical necessity criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for substance abuse determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

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

Inpatient

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

Intermediate

1. Partial Hospitalization Program (PHP);

2. Intensive Outpatient Program (IOP); and
3. Day treatment.

Outpatient

1. Traditional outpatient services, including individual and group therapy services;
2. Diagnostic and treatment services for biologically based mental illnesses;
3. Medication management services;
4. Biofeedback;
5. Psychological Testing;
6. *Applied behavioral analysis* and *autism spectrum disorder*; and
7. Rehabilitation.

Expenses for these services are covered, if *medically necessary* and may be subject to prior authorization.

Limitations:

Please see the Schedule of Benefits for more information regarding services that require prior authorization and specific benefit, day or visit limits, if any.

Mammography Screening

Covered service expenses under this benefit are provided for two screening mammography views per breast to detect breast cancer in adult women. A screening mammography means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic woman and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. Coverage also includes the professional interpretation of film.

Coverage includes:

- a. If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;
- b. If a woman is at least forty years of age but under fifty years of age, either of the following:
 - i. One screening mammography every two years; or
 - ii. If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.
- c. If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

Mastectomy Benefits

Covered service expenses for a mastectomy include reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Medical and Surgical Expense Benefits

Medical *covered service expenses* include, but are not 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. The following are not hospital confinement under this policy: confinement 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.
 - 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, that 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.
 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 services using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
 8. For chemotherapy (including *oral 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 *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint. See the Schedule of Benefits for benefit levels or additional limits.
 13. For reconstructive breast surgery charges as a result of a partial or total mastectomy for breast cancer.
 14. For routine patient care for patients enrolled in an *eligible cancer clinical trial*.
 15. 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.
 16. 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.
 17. Allergy testing, injections and serum.
 18. X-ray and other radiology services.
 19. Magnetic Resonance Imaging (MRI).
 20. CAT scans.
 21. Positron emission tomography (PET scanning).
 22. For routine care costs that are incurred in the course of a clinical trial that is deemed an *experimental or investigational treatment* if the services provided are otherwise considered *covered services* under the *policy*.
 23. Cytologic screenings for cervical cancer.
 24. Cochlear Implants.
 25. Vision correction as a result of a surgery or accident.

When available in your area, your coverage will include online visit services. Covered Services include a medical consultation using the internet via a webcam, chat or voice. See Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. Non Covered Services include, but are not limited to communications used for:

- Reporting normal lab or other test results.
- Office appointment requests.
- Billing, insurance coverage or payment questions.
- Requests for referrals to doctors outside the online care panel.
- Benefit precertification.
- Physician to Physician consultation.

Non-Routine Dental Services

Coverage for Non-Routine Dental Services for Specified Conditions is limited to the following:

1. Facility charges for Outpatient Services for the removal of teeth or for other dental processes if the patients' medical condition or the dental procedure requires a hospital setting to ensure the safety of the patient; or
2. Dental services for any of the following:
 - i. Transplant preparation.
 - ii. Initiation of immunosuppressive.
 - iii. Direct treatment of acute traumatic injury, cancer or cleft palate.

Outpatient Prescription Drug Expense Benefits

Covered service expenses in this benefit subsection include charges from a licensed *pharmacy* for:

1. A *prescription drug*, including for the treatment of biologically based mental illnesses on the same terms and conditions as any other disease or disorder.
2. Prescribed, self-administered anticancer medication.
3. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician*.
4. Off-label drugs.

Our drug formulary includes the list of drugs that our Pharmacy and Therapeutics Committee (PTC) has approved for our Members. The purpose of the PTC is to review and make decisions for changes to the drugs listed for coverage, the edits related to controls or limitations of drug coverage, and the policies and procedures governing provision of drug coverage under the formularies. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets at least quarterly to consider additions and deletions based on new information or drugs that become available.

See the Schedule of Benefits for benefit levels.

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

Off-Label Drugs

Off-label drugs are:

- a. Recognized for treatment of the indication in at least one (1) standard reference compendium; or
- b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

As used in this section, Standard Reference Compendia means (a) The American Hospital Formulary Service Drug Information (b) The American Medical Association Drug Evaluation or (c) The United States Pharmacopoeia-Drug Information.

Non-Formulary and Tiered Formulary Contraceptives:

Under Affordable Care Act, you have the right to obtain contraceptives that are not listed on the formulary (otherwise known as "non-formulary drugs") and tiered contraceptives (those found on a formulary tier other than "Tier 0 – no cost share") at no cost to you on your or your *medical practitioner's* request. 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.

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.

Prescription Drug Exception Process

1. 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.

2. 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 expedited exception request be granted, we will provide coverage of the non-formulary drug for the duration of the exigency.

3. 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 (IRO).

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.

For a prior approval related to a chronic condition, the approval for an approved drug will be honored for the lesser of 12 months or the last day of the covered person's enrollment under the policy.

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 otherwise not required by the Affordable Care Act, blood, or blood plasma unless listed on the formulary.
3. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
4. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
5. For a refill dispensed more than 12 months from the date of a *physician's* order.
6. 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 those which we must cover under Federal law with a *prescription order*.
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).

For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.

Pediatric Vision Expense Benefits

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

1. Routine vision screening, including dilation and with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) in glass or plastic, or initial supply of contacts every calendar year;
 - a. Other lens options included are: Fashion and Gradient Tinting, Ultraviolet Protective Coating, Oversized and Glass-Grey #3 Prescription Sunglass lenses, Polycarbonate lenses, Blended Segment lenses, Intermediate Vision lenses, Standard Progressives, Premium Progressives (Varilux®, etc.), Photochromic Glass Lenses, Plastic Photosensitive Lenses (Transitions®), Polarized Lenses, Standard Anti-Reflective (AR) Coating, Premium AR Coating, Ultra AR Coating, and Hi-Index Lenses.
3. One pair of frames 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; or
4. Out of Network care, except where 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. Examples of these services are screenings for cervical cancer and mammography.
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.
5. Covers without cost sharing:
 - a. Screening for *tobacco use*; and
 - b. For those who *use tobacco* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
 - i. Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and

- ii. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a healthcare provider without prior authorization.

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

Benefits for *covered expenses* for preventive care expense and chronic disease management benefits may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value preventive services from *network providers*. Reasonable medical management techniques may result in the application of deductibles, coinsurance provisions, or *copayment amounts* to services when a *covered person* chooses not to use a high value service that is otherwise exempt from deductibles, coinsurance provisions, and *copayment amounts*, when received from a *network provider*.

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

Covered Preventive Services for Adults include:

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; and
 - 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. A baseline mammogram for women 35 to 39 years of age. Breast Cancer Mammography screenings every 1 to 2 years for women over 40. A mammogram at the age and intervals considered *medically necessary* by the woman's health care provider for women under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors;
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 include:

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; and
 - 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.

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 1-877-687-1189 to 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 at Ambetter.BuckeyeHealthPlan.com.

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

Rehabilitation, Habilitation, and Skilled Nursing Facility Expense Benefits

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the member's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement, or maintain the member's abilities, in a reasonable length of time in the appropriate Inpatient setting.

Covered service expenses include services provided or expenses incurred for *rehabilitation* services (including cardiac rehabilitation) 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 services.
 - 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 medical practitioners*.

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*.

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*.

Covered service expenses shall be provided for *medically necessary habilitation* services, including, but not limited to:

- a. *Habilitation* services to children ages 0 to 21 with a medical diagnosis of *autism spectrum disorder*, which at a minimum shall include:
 - i. Out-patient physical *habilitation* services including speech and language therapy and/or occupational therapy, performed by a licensed therapist. 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. Mental/behavioral health outpatient services performed by a licensed psychologist, psychiatrist, or *physician* to provide consultation, assessment, development, and oversight of treatment plans.

Exclusions:

Non-Covered Services for physical medicine and rehabilitation include, but are not limited to:

1. Admission to a Hospital mainly for physical therapy;
2. Long term rehabilitation in an Inpatient setting.

Limitations:

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

Respite Care Expense Benefits

Respite care is covered on an inpatient or outpatient basis to allow temporary relief to family members from the duties of caring for a Covered Person. Respite days that are applied toward the Deductible are considered benefits provided and shall apply against any Maximum Benefit limit for these services. Respite Care coverage is limited to 14 days per benefit period.

Second Medical Opinion

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

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

If requested, the second opinion consultation is to be provided by a *physician* of the *member's* choice. The *member* may select a *network provider* listed in the Healthcare Provider Directory. If a *member* chooses a *network provider*, he or she will only be responsible for the applicable co-payment for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to the additional co-payment.

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:

Transplants are a covered benefit when preauthorized in accordance with this contract. Transplant services must be provided by a contracted provider and facility, and meet other medical criteria as set by medical Management Policy.

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

1. Pre-transplant evaluation.
2. Pre-transplant harvesting.
3. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *member* to prepare for a later transplant, whether or not the transplant occurs.
4. High dose chemotherapy.
5. Peripheral stem cell collection.
6. The transplant itself, not including the acquisition cost for the organ or bone marrow (except at a *Center of Excellence*).
7. Post-transplant follow-up.
8. 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.
9. 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, however, you must make the arrangements.

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 approved as a *medically necessary* transplant.

Transplant Benefit expenses are limited to \$10,000 for transportation and lodging per transplant, and \$30,000 for donor search per 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.

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. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
4. To keep a donor alive for the transplant operation.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
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.
7. Child care.
8. Mileage within the medical transplant facility city.
9. Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us.
10. Frequent Flyer miles.
11. Coupons, Vouchers, or Travel tickets.
12. Prepayments or deposits.

13. Services for a condition that is not directly related, or a direct result, of the transplant.
14. Telephone calls.
15. Laundry.
16. Postage.
17. Entertainment.
18. Interim visits to a medical care facility while waiting for the actual transplant procedure.
19. Travel expenses for donor companion/caregiver.
20. Return visits for the donor for a treatment of a condition found during the evaluation.

Wellness and Other Program Benefits

Benefits may be available from time to time to members for participating in certain programs that we may make available in connection with this Contract. Such programs may include wellness programs, disease or case management programs, and other programs. The benefits available to members for participating in such programs are described on the Schedule of Benefits. You may obtain information regarding the particular programs available at any given time by visiting our website at Ambetter.BuckeyeHealthPlan.com or by contacting Member Services by telephone at 1-877-687-1189. The 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 program information available on our website or by contacting us.

PRIOR AUTHORIZATION

Prior Authorization Required

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

For services or supplies that require prior authorization, as shown on the Schedule of Benefits, *you* must obtain authorization from *us* before the *member*:

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

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 Abuse 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, within 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. Please see the *contract* Schedule of Benefits for specific details.

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

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

Prior Authorization Does Not Guarantee Benefits

Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *contract*. We will not retroactively deny pre-authorizations as long as the authorization was obtained based on complete and accurate submission of all necessary information relative to an eligible member and the provider renders services in good faith and pursuant to the authorization and all of the terms and conditions of the provider's contract with *us*.

Referrals

"Referral" means the process by which the *member's primary care provider* directs the *member* to seek and obtain Covered Services from other providers.

If *you* have a condition or disease that requires specialized medical care over a prolonged period, *you* may need a standing approval. If you receive a standing approval to a *specialist provider*, you will not need to get Prior Authorization or a Referral every time *you* see that *specialist provider*. If *your* condition or disease is life threatening, worsening, or disabling, *you* may need to receive a standing approval to a *specialist provider* or specialty care center with the expertise to treat the condition or disease.

To get a standing approval, call *your primary care provider*. *Your primary care provider* will work with our providers and specialists to ensure *you* receive a treatment plan based on medical needs. *We* will make a determination regarding standing approval within three (3) business days from after *we* receive all reasonably necessary and requested information.

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.

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*.

Services from Non-Network Providers

Except for emergency medical services, 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. Any services performed for a member by a *member's immediate family*.
3. 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 *policy's* Termination section.
2. For any portion of the charges that are in excess of the *eligible service expense*.
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*.
4. For breast reduction or augmentation.
5. For the reversal of sterilization and vasectomies.
6. For non-therapeutic abortion.
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 *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.
11. For *cosmetic treatment*, except for *medically necessary reconstructive surgery* that is incidental to or follows *surgery* or an *injury* or is performed to correct a birth defect.
12. For diagnosis or treatment of learning disabilities.
13. For diagnosis or treatment of nicotine addiction except as expressly provided for under Preventive Care Expense Benefits.
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 vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
18. 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.
19. 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*.
20. 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.

21. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of 90 consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
22. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
23. For any services or supplies provided to a person not covered under the policy related to surrogate parenting or surrogate pregnancy, including, but not limited to, the bearing of a child by another woman for an infertile couple.
24. For or related to treatment of hyperhidrosis (excessive sweating).
25. For fetal reduction surgery.
26. Except as specifically identified as a *covered service expense* under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
27. 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.
28. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); biofeedback; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; 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; sclerotherapy for varicose veins; treatment of spider veins; smoking cessation drugs, programs or services, except as provided for under "Preventive Care Expense Benefits"; transportation expenses, unless specifically described in this *contract*.
29. For court ordered testing or care unless *medically necessary*.
30. 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.
31. Services or care provided or billed by a school, Custodial Care center for the developmentally disabled.
32. Bariatric Surgery.

TERMINATION

Termination of Contract

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*;
2. The date you are no longer eligible for coverage ---the last day of coverage is the last day of the month following the month in which the notice is sent by us unless you request an earlier termination effective date; or
3. You obtain other minimum essential coverage.

Refund upon Cancellation

We will refund any premium paid and not earned due to *policy* termination. After the policy has been continued beyond its original term, *you* may cancel the policy 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 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.

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 at the earliest of any of the following:
 - a. The *member's* discharge from the *hospital*;
 - b. The determination by the *member's* attending physician that inpatient care is no longer medically indicated for the *member*;
 - c. The *member's* reaching the limit for contractual benefits; or
 - d. The effective date of any new coverage.

REIMBURSEMENT

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

However, if payment by or for the *third party* has not been made by the time we receive acceptable *proof of loss*, we will pay regular *contract* benefits, as outlined in our "Claims" section and pursuant to the Ohio Prompt Payment Law, for the *member's loss*. We will have the right to be reimbursed to the extent permitted by Ohio law of benefits we provided or paid for the *illness or injury* if the *member* subsequently receives any payment from any *third party*. The *member* (or the guardian, legal representatives, estate, or heirs of the *member*) shall promptly reimburse us from the settlement, judgment, or any payment received from any *third party*.

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

1. To fully cooperate with us in order to obtain information about the *loss* and its cause.
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by us on behalf of a *member* in any claim made against any *third party*.
4. That we:
 - a. Will have a lien on all money received by a *member* in connection with the *loss* to the extent permitted by Ohio law.
 - b. May give notice of that lien to any *third party* or *third party's* agent or representative.
 - c. Will have the right to intervene in any suit or legal action to protect *our* rights.

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

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

If a dispute arises as to the amount a *member* must reimburse us, the *member* (or the guardian, legal representatives, estate, or heirs of the *member*) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by us until the dispute is resolved. Additionally, either party may file an action pursuant to Ohio law to resolve any issue related to the distribution of any money recovered from the *third party*.

However, if less than the full value of the *loss* is recovered because of comparative negligence, diminishment due to a party's liability pursuant to Ohio law, or by reason of the collectability of the full value of the claim for injury, death, or loss to person resulting from limited liability insurance or any other cause, *our* reimbursement amount shall decrease in the same proportion as the *member's* interest.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when you have healthcare coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable Expense.

Definitions

For the purpose of this Section, the following definitions shall apply:

- A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.
 - 1. Plan includes: Group and nongroup insurance contracts; Health insuring corporation (HIC) contracts; Coverage under group or nongroup closed panel plans (whether insured or uninsured); Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan as permitted by law.
 - 2. Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; Accident only coverage; Specified disease or specified accident coverage; Supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; School accident-type coverage; Non-medical components of long term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1 and 2 above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. This Plan means, in a COB provision the part of the Contract providing the healthcare benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Contract providing healthcare benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when you have healthcare coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.
- D. Allowable Expense is a healthcare expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable Expense. The following are examples of expenses that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
 2. If you are covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
 3. If you are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
 5. The amount of any benefit reduction by the Primary plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- E. Closed Panel Plan is a Plan that provides healthcare benefits to you primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When you are covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1.) **Non-Dependent or Dependent.**
The Plan that covers you other than as a dependent, (for example as an employee, member, policyholder, subscriber or retiree) is the Primary Plan and the Plan that covers you as a dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a dependent, and primary to the Plan covering you as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other plan is the Primary Plan.

2.) **Dependent Child Covered Under More Than One Plan.**

Unless there is a court decree stating otherwise, when a child is covered by more than one Plan the order of benefits is determined as follows:

- a. For a child whose parents are married or are living together, whether or not they have ever been married:
 - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
 - However, if one spouse's Plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that Plan.
- b. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - i. If a court decree states that one of the parents is responsible for the child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;
 - ii. If a court decree states that both parents are responsible for the child's healthcare expenses or healthcare coverage, the provisions of paragraph a. above shall determine the order of benefits;
 - iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the child, the provisions of paragraph a. above determine the order of benefits; or
 - iv. If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
 - The Plan covering the Custodial Parent, first;
 - The Plan covering the spouse of the Custodial Parent, second;
 - The Plan covering the noncustodial parent, third; and then
 - The Plan covering the spouse of the noncustodial parent, last.
- c. For a child covered under more than one Plan of individuals who are not the parents of the child, the provisions of paragraph a. or b. above shall determine the order of benefits as if those individuals were the parents of the child.

3.) **Active Employee or Retired or Laid-off Employee**

The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a dependent of an active employee and you are a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

4.) **COBRA or State Continuation Coverage**

If Your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering You as an employee, member, subscriber or retiree or covering you as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

5.) **Longer or Shorter Length of Coverage**

The Plan that covered you as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan. If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared

equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

- 6.) **If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.**

Effect on the Benefits of This Plan

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

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other Plans. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering you. We need not tell, or get the consent of, any person to do this. You, to claim benefits under This Plan, must give us any facts we need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by us is more than it should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid, or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us at 1-877-687-1189 or Ambetter.BuckeyeHealthPlan.com. You should also refer to the Complaint and Appeals procedures. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at <http://insurance.ohio.gov>.

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.

Cooperation Provision

Each *member*, or other person acting on his or her behalf, must cooperate fully with us to assist us in determining *our* rights and obligations under the *contract*.

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 45 days after receipt of *proof of loss*. If we do not pay within such period, we shall pay interest at the rate of 18 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 healthcare 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.

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. A grievance may be filed for issues including quality of care, physician behavior, waiting time for services and involuntary disenrollment. You have up to 180 calendar days to file a Grievance. The 180 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 thirty (30) business days following receipt of the grievance, or should a member's medical condition necessitate and expedited review a response within seven (7) days.

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.

How to Contact Us

Buckeye Health Plan of Ohio
4349 Easton Way, Suite 400, Columbus, OH, 43219
1-877-687-1189, twenty-four hours per day, seven days a week.

INTERNAL CLAIMS AND APPEALS PROCEDURES AND EXTERNAL REVIEW

Overview

If you need help: If you do not understand your rights or if you need assistance understanding your rights or you do not understand some or all of the information in the following provisions, you may contact Buckeye Health Plan at the Member Services Department, 4349 Easton Way, Suite 400, Columbus, OH, 43219, by telephone at 1-877-687-1189, by fax at 1-866-719-5404 or Ambetter.BuckeyeHealthPlan.com.

Internal Claims and Appeals Procedures: When a health insurance plan denies a claim for a treatment or service (a claim for plan benefits, *you* have already received (post-service claim denial) or denies *your* request to authorize treatment or service (pre-service denial), *you*, or someone *you* have authorized to speak on *your* behalf (an authorized representative), can request an appeal of the plan's decision. If the plan rescinds *your* coverage or denies *your* application for coverage, *you* may also appeal the plan's decision. When the plan receives *your* appeal, it is required to review its own decision. When the plan makes a decision, it is required to notify *you* (provide notice of an *adverse benefit determination*) including:

- The reasons for the plan's decision;
 - *Your* right to file appeal the decision;
 - *Your* right to request an *external review*; and
 - The availability of a Consumer Assistance Program at The Ohio Department of Insurance.
- If *you* do not speak English, *you* may be entitled to receive appeals' information in *your* native language upon request.
 - When *you* request an *internal appeal*, the plan must give *you* its decision as soon as possible, but no later than:
 - 72 hours after receiving *your* request when *you* are appealing the denial for urgent care. (If *your* appeal concerns urgent care, *you* may be able to have the internal appeal and external reviews take place at the same time).
 - 30 days for appeals of denials of non-urgent care *you* have not yet received.
 - 60 days for appeals of denials of services *you* have already received (post-service denials).
 - No extensions of the maximum time limits will be permitted without *your* consent.

Continuing Coverage: *The plan cannot terminate your benefits until all of the appeals have been exhausted. However, if the plan's decision is ultimately upheld, you may be responsible for paying any outstanding claims or reimbursing the plan for claims' payments it made during the time of the appeals.*

Cost and Minimums for Appeals: There is no cost to *you* to file an appeal and there is no minimum amount required to be in dispute.

Defined terms: Any terms appearing in *italics* are defined at the end of these provisions.

Emergency medical services: If the plan denies a claim for an emergency medical service, *your* appeal will be handled as an *expedited appeal*. *The plan will advise you at the time it denies the claim that you can file an expedited internal appeal. If you have filed for an expedited internal appeal, you may also file for an expedited external review (see "Simultaneous urgent claim, expedited internal review and external review").*

Your rights to file an appeal of denial of health benefits: *You or your authorized representative, such as your healthcare provider, may file the appeal for you, in writing, either by mail or by facsimile (fax). For an urgent*

request, you may also file an appeal by telephone:

Buckeye Health Plan at the Appeals Unit, 4349 Easton Way, Suite 400, Columbus, OH, 43219, by telephone at 1-877-687-1189, by fax at 1-866-719-5404 or Ambetter.BuckeyeHealthPlan.com.

Please include in *your* written appeal or be prepared to tell us the following:

- Name, address and telephone number of the insured person;
- The insured's health plan identification number;
- Name of healthcare provider, address and telephone number;
- Date the healthcare benefit was provided (if a post-claim denial appeal);
- Name, address and telephone number of an *authorized representative* (if appeal is filed by a person other than the insured); and
- A copy of the notice of *adverse benefit determination*.

Rescission of coverage: If the plan rescinds (withdraws) *your* coverage, *you* may file an appeal according to the following procedures. The plan cannot terminate *your* benefits until all of the appeals have been exhausted. Since a rescission means that no coverage ever existed, if the plan's decision to rescind is upheld, *you* will be responsible for payment of all claims for *your* healthcare services.

Time Limits for filing an internal claim or appeal: *You* must file the internal appeal within 180 days of the receipt of the notice of claim denial (an adverse benefit determination). Failure to file within this time limit may result in the company's declining to consider the appeal.

Time Limits for an External Appeal: *You* have 180 days to file for an *external review* after receipt of the plan's *final adverse benefit determination*.

Your Rights to a Full and Fair Review. The plan must allow *you* to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.

- The plan must provide *you*, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to give *you* a reasonable opportunity to respond prior to that date; and
- The adverse determination must be written in a manner understood by *you*, or if applicable, *your* authorized representative and must include all of the following:

The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);

Information sufficient to identify the claim involved, including the date of service, the healthcare provider;

A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; and

Your right to an independent internal review.

- As a general matter, the plan may deny claims at any point in the administrative process on the basis that it does not have *sufficient information*; such a decision, however, will allow *you* to advance to the next stage of the claims process.

Other Resources to help you

Department of Insurance: For questions about *your* rights or for assistance *you* may also contact the Consumer Services Division at the Ohio Department of Insurance 1-800-686-1526.

Language services are available from the health benefit plan and from The Ohio Department of Insurance.

Your rights to appeal and the instructions for filing an appeal are described in the provisions following this Overview.

INTERNAL CLAIMS AND APPEALS

Non-urgent, Pre-Service claim denial

For a non-urgent *pre-service claim*, the plan will notify *you* of its decision as soon as possible but no later than 15 days after receipt of the claim.

If the plan needs more time, it will contact *you*, in writing, telling *you* the reasons why it needs more time and the date when it expects to have a decision for *you*, which should be no later than 15 days.

If the plan needs additional information from *you* before it can make its decision, it will provide a notice to *you*, describing the information needed. *You* will have 45 days from the date of the plan's notice to provide the information. If *you* do not provide the additional information, the plan can deny *your* claim. In which case, *you* may file an appeal.

The plan must make its decision within 48 hours after receipt of the information or at the end of the 45 days, whichever comes first.

Urgent Pre-service Care claim denial

If your claim for benefits is urgent, you or your authorized representative, or your healthcare provider (physician) may contact us with the claim, orally or in writing.

If the claim for benefits is one *involving urgent care*, we will notify *you* of our decision as soon as possible, but no later than 72 hours after we receive *your* claim provided *you* have given us information sufficient to make a decision.

To assure *you* receive notice of our decision, we will contact *you* by telephone or facsimile (fax) or by another method meant to provide the decision to *you* quickly.

In determining whether a claim involves urgent care, the plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. **However, if a physician with knowledge of *your* medical condition determines that a claim involves urgent care, or an emergency, the claim must be treated as an urgent care claim.**

Simultaneous urgent claim and expedited internal review:

In the case of a claim involving urgent care, *you* or *your* authorized representative may also request an expedited internal review. A request for expedited internal review may be submitted orally or in writing by the claimant; and all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other expeditious method.

Simultaneous urgent claim, expedited internal review and external review:

You, or *your* authorized representative, may request an expedited external review if both the following apply

(1) *You* have filed a request for an expedited internal review; and

(2) After a final adverse benefit determination, either of the following applies:

(a) *Your* treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of *you*, or would jeopardize *your* ability to regain maximum function, if treated after the time frame of a standard external review; or

(b) The final adverse benefit determination concerns an admission, availability of care, continued stay, or healthcare service for which *you* received emergency services, but have not yet been discharged from a facility.

Concurrent Care Decisions

Reduction or termination of ongoing plan of treatment: If we have approved an ongoing plan or course of treatment that will continue over a period of time or a certain number of treatments and we notify *you* that we have decided to reduce or terminate the treatment, we will give *you* notice of that decision allowing sufficient time to appeal the determination and to receive a decision from us before any interruption of care occurs.

Request to extend ongoing treatment: If *you* have received approval for an ongoing treatment and wish to extend the treatment beyond what has already been approved, we will consider *your* appeal as a request for urgent care. If *you* request an extension of treatment at least 24 hours before the end of the treatment period, we must notify *you* soon as possible but no later than 24 hours after receipt of the claim.

An appeal of this decision is conducted according to the urgent care appeals procedures.

Concurrent urgent care and extension of treatment: Under the concurrent care provisions, any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by the plan must be decided as soon as possible, taking into account the medical urgencies, and notification must be provided to the claimant within 24 hours after receipt of the claim, provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Non-urgent request to extend course of treatment or number of treatments: If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the plan does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a pre-service claim or a post-service claim.

If the request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a claim involving urgent care and decided in accordance with the urgent care claim timeframes, e.g., as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt.

Post-service appeal of a claim denial (retrospective)

If *your* appeal is for a *post-service claim denial*, we will notify *you* of our decision as soon as possible but no later than 60 days after we have received *your* appeal. If we need more time, we will contact *you*, telling *you* about the reasons why we need more time and the date when we expect to have a decision for *you*, which should be no later than 14 days, provided that we determine that such an extension is necessary due to matters beyond our control, and we notify *you* prior to the expiration of the initial 30 days period. If the reason we need more time to make a decision is because *you* have not given us necessary information, *you* will have 45 days from the date we notify *you* to give us the information. We will describe the information needed to make our decision in the notice we send *you*. This is also known as a “retrospective review.” The plan will notify *you* of its determination as soon as possible but no later than 5 days after the benefit determination is made.

The plan will let *you* know before the end of the first 30 day period, explaining the reason for the delay, requesting any additional information needed, and advising *you* when a final decision is expected. If more information is requested, *you* have at least 45 days to supply it. The claim then must be decided no later than 15 days after *you* supply the additional information or the period given by the plan to do so ends, whichever comes first. The plan must get *your* consent if it wants more time after its first extension. The plan must give *you* notice that *your* claim has been denied in whole or in part (paying less than 100% of the claim) before the end of the time allotted for the decision.

EXTERNAL REVIEW

Right to External Review

Under certain circumstances, *you* have a right to request an external review of our adverse benefit decision by an independent review organization or by the superintendent of insurance, or both.

If *you* have filed internal claims and appeals according with the procedures of this plan, and the plan has denied or refused to change its decision, or if the plan has failed, because of its actions or its failure to act, to provide *you* with a *final determination* of *your* appeal within the time permitted, or if the plan waives, in writing, the requirement to exhaust the internal claims and appeals procedures, *you* may make a request for an *external review* of an *adverse benefit determination*.

All requests for an *external review* must be made within 180 days of the date of the notice of the plan's *final adverse benefit determination*. Standard requests for an external review must be provided in writing; requests for expedited external reviews, including experimental/investigational, may be submitted orally or electronically. When an oral or electronic request for review is made, written confirmation of the request must be submitted to the plan no later than 5 days after the initial request was made.

You may file the request for an external review by contacting the plan

Buckeye Health Plan at the Appeals Unit, 4349 Easton Way, Suite 400, Columbus, OH, 43219, by telephone at 1-877-687-1189, by fax at 1-866-719-5404 or Ambetter.BuckeyeHealthPlan.com.

Non-urgent request for an external review

Unless the request is for an expedited external review, the plan will initiate an external review within 5 days after it receives *your* written request if *your* request is complete. The plan will provide *you* with notice that it has initiated the external review that includes:

(a) The name and contact information for the assigned independent review organization or the superintendent of insurance, as applicable, for the purpose of submitting additional information; and

(b) Except for when an expedited request is made, a statement that *you* may, with 10 business days after the date of receipt of the notice, submit, in writing, additional information for either the independent review organization or the superintendent of insurance to consider when conducting the external review.

If *your* request is not complete, the plan will notify *you* in writing and include information about what is needed to make the request complete.

If the plan denies *your* request for an external review on the basis that the adverse benefit determination is not eligible for an external review, the plan will notify *you*, in writing, the reasons for the denial and that *you* have a right to appeal the decision to the superintendent of insurance.

If the plan denies *your* request for an external review because *you* have failed to exhaust the Internal Claims and Appeals Procedure, *you* may request a written explanation, which the plan will provide to *you* within 10 days of receipt of *your* request, explaining the specific reasons for its assertion that *you* were not eligible for an *external review* because *you* did not comply with the required procedures.

Request for external review to the Department of Insurance: If the plan denies *your* request for an *external review*, *you* may file a request for the superintendent of insurance to review the plan's decision by contacting Consumer Services Division at 1-800-686-1526 between 8:00 a.m. and 5:00 p.m., eastern standard time or by sending a written request addressed to: Consumer Services, The Ohio Department of Insurance, 50 West Town St., Suite 300, Columbus, Ohio 43215. Information about external reviews is also available on the Department's website: www.insurance.ohio.gov.

If the DOI upholds the plan's decision: If *you* file a request for an external review with the DOI, and if the DOI upholds the plan's decision to deny the *external review* because *you* did not follow the plan's internal claims and appeals procedures, *you* must resubmit *your* appeal according to the plan's internal claims and appeals procedures within 10 days of the date of *your* receipt of the superintendent's decision. The clock will begin running on all of the required time periods described in the internal claims and appeals procedures when *you* receive this notice from the superintendent.

If the plan's failure to comply with its obligations under the internal claims and appeals procedures was considered (i) *de minimis*, (ii) not likely to cause prejudice or harm to *you* (claimant), (iii) because we had a good reason or our failure was caused by matters beyond our control (iv) in the context of an ongoing good-faith exchange of information between the plan and *you* (claimant) or *your authorized representative* and (v) not part of a pattern or practice of our not following the internal claims and appeals procedures, then *you* will not be deemed to have exhausted the internal claims and appeals requirements. *You* may request an explanation of the basis for the plan's asserting that its actions meet this standard.

Expedited external review for experimental and/or investigational treatment: *You* may request an external review of an adverse benefit determination based on the conclusion that a requested healthcare service is experimental or investigational, except when the requested healthcare service is explicitly listed as an excluded benefit under the terms of the health benefit plan.

To be eligible for an external review under this provision, *your* treating physician shall certify that one of the following situations is applicable:

- (1) Standard healthcare services have not been effective in improving *your* condition;
- (2) Standard healthcare services are not medically appropriate for *you*; or
- (3) There is no available standard healthcare service covered by the health plan issuer that is more beneficial than requested healthcare service.

The request for an expedited external review under this provision may be requested orally or by electronically. For Expedited/Urgent requests, *your* healthcare provider can orally make the request on *your* behalf.

Independent Review Organization: An *external review* is conducted by an independent review organization (IRO) selected on a random basis as determined in accordance with Ohio law. The IRO will provide *you* with a written notice of its decision to either uphold or reverse the plan's *adverse benefit determination* within 30 days of receipt of a *standard external review (not urgent)*.

If an *expedited external review (urgent)* was requested, the IRO will provide a determination as soon as possible or within 72 hours of receipt of the expedited request. The IRO's decision is binding on the company. If the IRO reverses the health benefit plan's decision, the plan will immediately provide coverage for the healthcare service or services in question.

If the superintendent or IRO requires additional information from *you* or *your* healthcare provider, the plan will tell *you* what is needed to make the request complete.

If the plan reverses its decision: If the plan decides to reverse its adverse determination before or during the external review, the plan will notify *you*, the IRO, and the superintendent of insurance within one business day of the decision.

After receipt of healthcare services: No expedited review is available for adverse benefit determinations made after receipt of the healthcare service or services in question.

Emergency medical services: If plan denies coverage for an emergency medical service, the plan will also advise at the time of denial that *you* request an expedited internal and *external review* of the plan's decision.

Review by the Department of Insurance: If the plan has made an adverse benefit determination based on a contractual issue (e.g., whether a service or services are covered under *your* contract of insurance), *you* may request an external review by the department of insurance.

If the IRO and DOI uphold the plan's decision, *you* may have a right to file a lawsuit in any court having jurisdiction.

Definitions

Adverse benefit determination means any of the following:

(A) "Adverse benefit determination" means a decision by a health plan issuer:

(1) To deny, reduce, or terminate a requested healthcare service or payment in whole or in part, including all of the following:

(a) A determination that the healthcare service does not meet the health plan issuer's requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness, including experimental or investigational treatments;

(b) A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a nonemployer group, to participate in a plan or health insurance coverage;

(c) A determination that a healthcare service is not a covered benefit;

(d) The imposition of an exclusion, including an exclusion for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.

(2) Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a nonemployer group;

(3) To rescind coverage on a health benefit plan.

a denial, reduction, or termination of, or

a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or

failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of,

or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not *medically necessary*.

An "adverse benefit determination" also includes a rescission of the participant or beneficiary.

Ambulatory review means utilization review of healthcare services performed or provided in an outpatient setting.

Authorized representative means an individual who represents *you* in an internal appeal or external review process of an adverse benefit determination who is any of the following:

- (1) A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;
- (2) A person authorized by law to provide substituted consent for a covered individual;
- (3) A family member but only when *you* are unable to provide consent.

Claim involving urgent care means any claim for Medicare care or treatment with respect to the application of the time periods for making non-urgent care determinations

- Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
- In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment is the subject of the claim.

The determination whether a claim is a "claim involving urgent care" will be determined by the plan; or, by a physician with knowledge of the claimant's medical condition.

You means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "*You*" does include *your* authorized representative with regard to an internal appeal or external review in accordance with division (C) of this section. "*You*" does not include *your* representative in any other context.

de minimis means something not important; something so minor that it can be ignored.

Emergency medical condition means a medical condition that manifests itself by such acute symptoms of sufficient severity, including 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 any of the following:

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

Emergency services means the following:

- (1) A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition;
- (2) Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

As used when referring to *emergency services* or *emergency medical condition*, "Stabilize" means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of an individual's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

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

(b) In the case of a woman having contractions, “stabilize” means such medical treatment as may be necessary to deliver, including the placenta.

Transfer has the same meaning as in section 1867 of the “Social Security Act,” 49 Stat. 620 (1935), 42 U.S.C.A. 1395dd, as amended.

Final adverse benefit determination means an adverse benefit determination that is upheld at the completion of a health plan issuer's internal appeals process.

Healthcare professional means a physician, psychologist, nurse practitioner, or other healthcare practitioner licensed, accredited, or certified to perform healthcare services consistent with state law.

Healthcare provider or provider means a healthcare professional or facility.

Independent review organization (IRO) means an entity that is accredited by a nationally recognized private accrediting organization to conduct independent external reviews of adverse benefit determinations and by the superintendent of insurance in accordance with Ohio law.

Language assistance means translation services provided if requested. Contact customer service at 1-877-687-1189 if oral or written services are needed.

(1) The plan or issuer must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;

(2) The plan or issuer must provide, upon request, a notice in any applicable non-English language; and

(3) The plan or issuer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan or issuer.

Applicable non-English language. With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

Medical care means the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body and for transportation primarily for and essential to the provision of such care.

Post-service claim means any claim for a benefit under a group health plan that is not a “pre-service claim.”

Pre-service claim means any claim for a benefit under a group health plan, with respect to which the terms of the plan condition receipt of the benefit, in completely or in part, on approval of the benefit in advance of obtaining medical care.

Physician means a provider who holds a certificate under Ohio law authorizing the practice of medicine and surgery or osteopathic medicine and surgery or a comparable license or certificate from another state.

Rescission means a cancellation or discontinuance of coverage that has a retroactive effect. “Rescission” does not include a cancellation or discontinuance of 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

Urgent care claims: If your claim involves *urgent care*, we will notify you as soon as possible but no later than 72 hour after we have received the appeal for a denied claim for urgent care.

Utilization review means a process used to monitor the use of, or evaluate the clinical necessity,

appropriateness, efficacy, or efficiency of, healthcare 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.

GENERAL PROVISIONS

Entire Contract

This *contract*, with the application, Schedule 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 misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a *member*;
2. A copy of the application, and any amendments, has been furnished to the *member(s)*, or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *member*. A *member's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

Repayment for Fraud, Misrepresentation or False Information

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

Conformity with 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.

Hold Harmless

Buckeye Health Plan is not a member of any guaranty fund, and in the event that *we* become insolvent, member is protected only to the extent that the hold harmless provision under 1751.13 applies to those healthcare services rendered.

In addition, in the event *we* become insolvent, the member may be financially responsible for healthcare services rendered by a provider or healthcare facility that is not under contract with *us*. However, the member is protected only to the extent that the hold harmless provision under 1751.13 applies to those healthcare services rendered.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Buckeye Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Buckeye Health Plan 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 1-877-687-1189 (TTY/TDD 1-877-941-9236)。
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Buckeye Health Plan 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 1-877-687-1189 (TTY/TDD 1-877-941-9236) an.
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Buckeye Health Plan، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Pennsylvania Dutch:	Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from Buckeye Health Plan, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kaw! 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Buckeye Health Plan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1189 (TTY/TDD 1-877-941-9236).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Buckeye Health Plan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Buckeye Health Plan, 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 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Cushite:	Yoo sii ykn namaa gargaaraa jirtuu wa'ee Ambetter from Buckeye Health Plan gaaffi qabaatan ta'ee gargaarsaa fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana wajjin dubadhuu, 1-877-687-1189 irra bilbilli (TTY/TDD 1-877-941-9236).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Buckeye Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1189 (TTY/TDD 1-877-941-9236)로 전화하십시오.
Italian:	Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from Buckeye Health Plan, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami il 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Japanese:	Ambetter from Buckeye Health Plan について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-687-1189 (TTY/TDD 1-877-941-9236)までお電話ください。
Dutch:	Als u of iemand die u helpt vragen heeft over Ambetter from Buckeye Health Plan, hebt u recht op gratis hulp en informatie in uw taal. Bel 1-877-687-1189 (TTY/TDD (teksttelefoon) 1-877-941-9236) om met een tolk te spreken.
Ukrainian:	В разі виникнення у вас або особи, якій ви допомагаєте, будь-яких запитань щодо програми страхування Ambetter from Buckeye Health Plan ви маєте право отримати безкоштовну допомогу та інформацію на своїй рідній мові. Щоб поговорити з перекладачем, зателефонуйте за номером 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Romanian:	Dacă dvs. sau o persoană pe care o asistați are întrebări despre Ambetter from Buckeye Health Plan, aveți dreptul să obțineți asistență și informații în limba dvs. în mod gratuit. Pentru a vorbi cu un interpret, apălați 1-877-687-1189 (TTY/TDD 1-877-941-9236).

Statement of Non-Discrimination

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

Ambetter from Buckeye Health Plan:

- 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 from Buckeye Health Plan at 1-877-687-1189 (TTY/TDD 1-877-941-9236).

If you believe that Ambetter from Buckeye Health Plan 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: Buckeye Health Plan at the Appeals Unit, 4349 Easton Way, Suite 400, Columbus, OH 43219, 1-877-687-1189 (TTY/TDD 1-877-941-9236), Fax 1-866-719-5404. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Buckeye Health Plan 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>.

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