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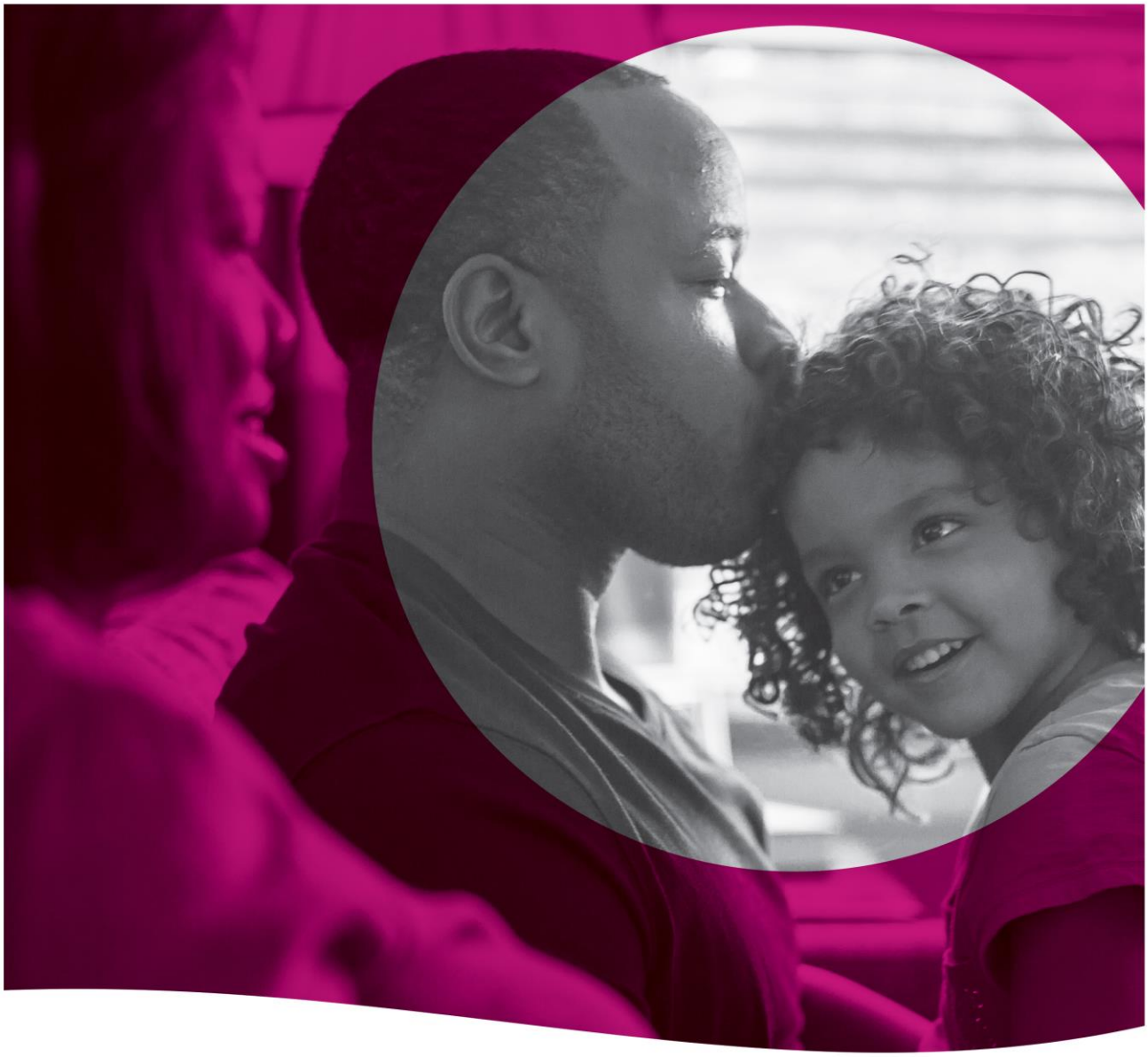
2018 Evidence of Coverage



AmbetterHealthNet.com

MAJOR MEDICAL EXPENSE INSURANCE POLICY

AMBETTER FROM HEALTH NET

Home Office: 1230 W. Washington St., Ste. 401, Tempe, AZ 85281

ISSUED BY

HEALTH NET OF ARIZONA, INC.

Tempe, Arizona

Welcome to Health Net. This booklet is *your Policy*. It explains what *your* benefits are, how *you* can access these benefits, and the limitations and exclusions that apply to *covered services*. In this *policy*, the terms "*You*" or "*Your*" will refer to the covered person named on the Schedule of Benefits, and "*We*," "*Our*" or "*Us*" will refer to Ambetter from Health Net ("Ambetter"). For *your* convenience, *we* have included a Definitions Section, which will explain the meaning of special words and phrases used throughout this *Policy*. Be sure to check these definitions as they may differ from other Health Plans.

AGREEMENT AND CONSIDERATION

In consideration of *your* application and the timely payment of premiums, we will provide benefits to *you*, the covered person, for *covered services* as outlined in this *policy*. Benefits are subject to *policy* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

Guaranteed renewable means that this *policy* will renew each year on the anniversary date unless terminated earlier in accordance with *policy* terms. *You* may keep this *policy* in force by timely payment of the required premiums. However, we may decide not to renew the *policy* as of the renewal date if: (1) we decide not to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a covered person in filing a *claim* for *policy* benefits.

Annually, we may change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The *policy* plan, and age of covered persons, 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.

At least thirty-one (31) days' 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 *policy* or a change in a covered person's health. While this *policy* is in force, we will not restrict coverage already in force. Changes to this *policy* will be approved by the Arizona Insurance Department.

This *policy* contains *prior authorization* requirements. *You* may be required to obtain a *referral* from a *Primary Care Physician* in order to receive 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.

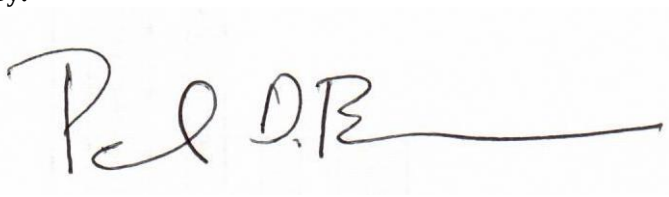
***You* are required to enroll each year in order to receive any subsidies for which *you* may be eligible.**

TEN DAY RIGHT TO RETURN

THIS *POLICY* SHOULD BE READ CAREFULLY. IF *YOU* HAVE QUESTIONS, CALL MEMBER SERVICES AT 1-888-926-5057 (TTY/TDD 1-888-926-5180). IF *YOU* ARE NOT SATISFIED WITH THIS *POLICY*, *YOU* MAY RETURN IT, IN PERSON OR BY MAIL, ALONG WITH *YOUR* IDENTIFICATION CARD TO HEALTH NET OF ARIZONA, INC., 1230 WEST WASHINGTON STREET, SUITE 401, TEMPE, ARIZONA 85281, WITHIN 10 DAYS FROM THE DATE IT WAS RECEIVED SO LONG AS COVERED SERVICES UNDER THIS *POLICY* HAVE NOT BEEN UTILIZED DURING THE 10 DAY PERIOD. IMMEDIATELY UPON SUCH DELIVERY OR MAILING, THIS *POLICY* SHALL BE DEEMED VOID AS OF ITS ORIGINAL EFFECTIVE DATE. ANY PREMIUM PAID WILL BE REFUNDED WITHIN 10 DAYS OF HEALTH NET'S RECEIPT OF THE RETURNED *POLICY*.

Health Net of Arizona Inc.

By:



Name: Paul Barnes
Title: President, Health Net of Arizona

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INTRODUCTION

PLEASE READ THIS IMPORTANT NOTICE ABOUT YOUR PLAN

AMBETTER FROM HEALTH NET HEALTH PLAN SERVICE AREA AND OBTAINING SERVICES FROM THE AMBETTER FROM HEALTH NET NETWORK PHYSICIANS HOSPITAL PROVIDERS

You are enrolled in an Ambetter from Health Net Plan. Benefits under this *Policy* are only available when *you* use an Ambetter from Health Net *Network Provider* (except as stated below) and live in the Ambetter from Health Net Service Area.

Obtaining Covered Services and Supplies under this *Policy:*

Please refer to this *Policy* whenever *you* require *medical services*.

It describes:

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

This *Policy*, the Schedule of Benefits, the application as submitted to the *Health Insurance Marketplace*, and any amendments or riders attached shall constitute the entire *policy* under which *covered services and supplies* are provided or paid for by *us*.

This *policy* should be read in its entirety. Since many of the provisions are interrelated, *you* should read the entire *policy* to get a full understanding of *your coverage*. Many words used in the *policy* have special meanings: these words are *italicized* and are defined for *you* in the Definitions section. This *policy* also contains exclusions, so please be sure to read this *policy* carefully.

If *you* have any questions about the Ambetter from Health Net Service Area, choosing *Your* Ambetter from Health Net *Primary Care Physician*, how to access *specialist* care, or *your* benefits, please contact Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

How to Contact Us

Ambetter from Health Net of Arizona
1230 W. Washington St., Ste. 401,
Tempe, AZ 85281

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

Member Services	855-926-5057
TDD/TTY	888-926-5180
Fax	866-687-0518
Emergency	911
24/7 Nurse Advice Line	1-844-265-1278

Interpreter Services

Ambetter from Health Net has a free service to help our *members* who speak languages other than

English. This service allows *you* and *your physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand.

Our interpreter services are provided at no cost to *you*. *We* have representatives that speak Spanish and have medical interpreters to assist with other languages.

Members who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation. To arrange for interpretation services, call Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) is a special tax-exempt custodial account or trust owned by an individual where contributions to the account may be used to pay for current and future qualified medical expenses. Please refer to *your* Schedule of Benefits to see if the plan *you* are enrolled in has an HSA Account. For *members* enrolled in an HSA compatible plan, the following terms apply.

Your high-deductible *health plan* may be used in conjunction with an HSA. However, individual *members* must satisfy federal HSA eligibility criteria in order to open and contribute to an HSA.

This *Policy* is administered by Ambetter from Health Net of Arizona, Inc. Health Net of Arizona, Inc. is not an HSA trustee, HSA custodian or a designated administrator for HSA's. Health Net of Arizona, Inc., its designee's and its affiliates do not provide tax, investment or legal advice to *members*.

MEMBERS ARE SOLELY RESPONSIBLE FOR ADHERING TO ALL FEDERAL REGULATIONS AND GUIDELINES CONCERNING HSA ELIGIBLE EXPENSES, CONTRIBUTIONS AND QUALIFIED WITHDRAWALS. IN ADDITION, EACH MEMBER WITH AN HSA IS RESPONSIBLE FOR NOTIFYING HIS/HER HSA CUSTODIAN OR TRUSTEE IF ENROLLMENT UNDER THIS PLAN HAS BEEN CANCELED OR TERMINATED.

THE TERMS OF THIS POLICY ARE CONFINED TO THE BENEFITS PROVIDED HEREIN AND DO NOT ENCOMPASS ANY INDIVIDUAL HSA FEE ARRANGEMENTS, ACCOUNT MAINTENANCE OR CONTRIBUTION REQUIREMENTS, APPLICATION PROCEDURES, TERMS, CONDITIONS, WARRANTIES, OR LIMITATIONS THERETO, OR GRIEVANCES AND CIVIL DISPUTES WITH ANY HSA CUSTODIAN OR TRUSTEE.

PLEASE CONSULT A PROFESSIONAL TAX ADVISOR FOR MORE INFORMATION ABOUT THE TAX IMPLICATIONS OF AN HSA OR HSA PROGRAM.

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 *your providers*.
3. Providing information to help *you* become an informed healthcare consumer.
4. Providing access to *covered services* and our *network providers*.
5. Providing coverage regardless of age, ethnicity or race, religion, gender, sexual orientation, national origin, physical or mental disability, and/or expected health or genetic status.

You have the right to:

1. Participate with *your providers* 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, *your* rights and responsibilities and our policies.
7. Candidly discuss with *your physician* and Medical Practitioners appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from *your Primary Care Physician* about what might be wrong (to the level known), treatment and any known likely results. *Your Primary Care Physician* can tell *you* about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for *your* approval for treatment unless there is an *emergency* and *your* life and health are in serious danger.
8. Voice Complaints or Grievances about our organization, any benefit or coverage decisions we (or our designated administrators) make, *your* coverage, or care provided.
9. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician(s)* of the medical consequences.
10. See *your* medical records.
11. Be kept informed of covered and non- *covered services*, program changes, how to access services, *Primary Care Physician* assignment, *providers*, advance directive information, *referrals* and *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify *you* at least 30 days before the *effective date* of the modifications. Such notices shall include a statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
12. A current list of *network providers*.
13. Select another *health plan* or switch health plans, within the guidelines of law, without any threats

or harassment.

14. Adequate access to qualified *physicians* and Medical Practitioners and treatment or services regardless of age, race, creed, sex, sexual preference, family structure, geographic location, health condition, national origin or religion.
15. Access *medically necessary* urgent and *emergency services* 24 hours a day and seven days a week.
16. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
17. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *Primary Care Physician's* instructions are not followed. *You* should discuss all concerns about treatment with *your Primary Care Physician*. *Your Primary Care Physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
18. Select *your Primary Care Physician* within the *network*. *You* also have the right to change *your Primary Care Physician* or request information on *network providers* close to *your* home or work.
19. Know the name and job title of people giving *you* care. *You* also have the right to know which *physician* is *your Primary Care Physician*.
20. An interpreter, available by phone, if *you* do not speak or understand English.
21. A second opinion by a *network physician* of *your* choice, regarding any medical diagnosis or treatment plan.
22. Make an Advance Directive for healthcare decisions. This includes planning treatment before *you* need it.
23. Advance Directives are forms *you* can complete to protect *your* rights for medical care. It can help *your Primary Care Physician* and other *providers* understand *your* wishes about *your* health. Advance Directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for *your*self. Examples of Advance Directives include:
    a. Living Will
    b. Healthcare Power of Attorney
    c. "Do Not Resuscitate" Orders

    Members also have the right to refuse to make Advance Directives. *You* should not be discriminated against for not having an Advance Directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all 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 physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician's* office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *Primary Care Physician*. *You* may change *your Primary Care Physician* verbally or in writing by contacting our Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* healthcare professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.

9. Supply, to the extent possible, information that we and/or *your* healthcare professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* healthcare professionals and *physicians*.
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 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. *Us*e any Emergency Room only when *you* think *you* have a medical *emergency*. For all other care, *you* should call *your Primary Care Physician* or access an *Urgent Care facility*.
14. Provide all information about any other medical coverage *you* have upon enrollment in this plan. If, at any time, *you* get other medical coverage besides this coverage, *you* m*us*t tell *us*.
15. Pay *your* monthly premium on time and pay all *deductible amounts*, *copayment amounts*, or *cost sharing percentages*. *Copayment Amounts* must be paid at the time of service.
16. Receive all of *your* healthcare services and supplies from *network providers*, except as specifically stated in this *contract*.
17. Inform the entity in which *you* enrolled for this *policy* if *you* have any changes to *your* name, address, or *family members* covered under this *policy* within 60 days from the date of the event.

Your Provider Directory

A listing of *network providers* is available online at www.ambetterhealthnet.com. We have plan *physicians*, *hospitals*, and other Medical Practitioners who have agreed to provide *you* healthcare services. *You* can find our *network providers* by visiting our website and *us*ing 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 1-888-926-5057 (TTY/TDD 1-888-926-5180). In order to obtain benefits, *you* m*us*t designate a *network Primary Care Physician* for each *member*. We can also help *you* pick a *Primary Care Physician* (*PCP*). We can make *your* choice of *Primary Care Physician* effective on the next b*us*iness day, if the selected *physician's* caseload permits. We will notify *you* if *your Primary Care Physician* leaves our *network. You* will be provided continued access, and *your coverage* will continue under the terms of this *contract* for at least sixty (60) days from that notice.

Call the Provider's office if *you* want to make an appointment. If *you* need help, call Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

Your Member ID Card

When *you* enroll, we will mail *you* a Member ID card after our receipt of *your* completed enrollment materials, which includes receipt of *your* initial binder payment. This card is proof that *you* are enrolled in an Ambetter from Health Net 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 number and *copayment amounts* required at the time of service. If *you* do not get *your* ID card within a few weeks after *you* enroll, please call Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180). We will send *you* another card.

Our Website

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

1. Finding a *network provider*.
2. Our programs and services, including programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the stat*us* of *your claims*, make payments and obtain a copy of *your* Member ID Card.
4. *Member* Rights and Responsibilities.
5. Notice of Privacy.
6. Current events and news with *your* Ambetter plan.
7. Our Formulary.
8. Selecting a *Primary Care Physician*.
9. *Deductible* and *copayment amounts*.
10. Making *your* premium payment.

Quality Improvement

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

1. Conducting a thorough check on 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.

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.

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

This section tells *you* meanings of some of the more important words *you* will see used in this *Policy*. Please read it carefully. It will help *you* understand this *Policy*.

Accident or ***Accidental*** means an unexpected, undesirable event that was unforeseen.

Acute means the sudden onset of an *illness* or *injury*, or a sudden change in a person's health stat*us*, requiring prompt medical attention, but which is of limited duration as determined by *us*.

Advanced Premium Tax Credit means payment of the tax credits specified in section 36B of the Internal Revenue 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 qualified health plan through a *Marketplace* in accordance with sections 1402 and 1412 of the Affordable Care Act. If *we* do not receive *Advanced Premium Tax Credits* with respect to *your* coverage for whatever reason, *your* monthly premium payment must equal the Premium amount that has not been reduced by *Advanced Premium Tax Credits*.

Adverse Benefit Determination means a decision by *us* which results in:

a. A denial of a request for service.
b. A denial, reduction or failure to provide or make payment in whole or in part for a covered benefit.
c. A determination that an admission, continued stay, or other health care service does not meet Our requirements for *medical necessity*, appropriateness, health care setting, or level of care or effectiveness.
d. A determination that a service is *experimental*, *investigational*, *cosmetic* treatment, not *medically necessary* or inappropriate.
e. Our decision to deny *coverage* based upon an eligibility determination.
f. A rescission of *coverage* determination as described in the General Provisions section of this *contract*.
g. A prospective review or retrospective review determination that denies, reduces or fails to provide or make payment, in whole or in part, for a covered benefit.

Refer to the Appeals & Grievance section of this *contract* for information on *your* right to appeal an *Adverse Benefit Determination*.

Aggravation means a new incident or *injury* in the same area where a previous *injury* had occurred.

Ambulance means a vehicle superficially designed, equipped and licensed for transporting the sick and/or injured.

Ambulatory Surgical Facility means a *facility* that meets the states' statutorily and/or professionally recognized standards and provides the following:

- It mainly provides a setting for *outpatient* surgeries; and,
- It does not provide more than 2 days of *inpatient* service; and,
- It has all of the medical equipment needed to support the surgery performed, x-ray and laboratory diagnostic *facilities*, and *emergency* equipment and supplies for *us*e in life threatening events; and,

- It has a medical staff that is supervised full-time by a *physician* and includes a registered nurse at all times when patients are in the *facility*; and,
- It maintains a medical record for each patient; and,
- It has a written agreement with a local *hospital* for the immediate transfer of patients who require greater care than can be furnished at the *facility*; and,
- It complies with all state and/or federal licensing and other requirements; and,
- It is not the office or clinic of one or more *physicians*.

Authorization or ***Authorized*** (also "*Prior Authorization*" or "*Approval*") means a decision to approve specialty or other *medically necessary* care for a *member* by the *member's PCP* or provider group.

Balance Billing means a *non- network provider* billing *you* for the difference between the provider's charge for a service and the *eligible service expense*. *Network providers* may not *balance bill you* for *covered expenses*.

Behavioral Therapy means interactive therapies derived from evidence based research, including applied behavior analysis, which includes discrete trial training, pivotal response training, intensive intervention programs and early intensive behavioral intervention.

Birth Center means a *facility* that is primarily a place for the delivery of a child at the end of a normal pregnancy, and meets all of the following tests:

1. It complies with all licensing and other legal requirements;
2. It is equipped to perform all of the needed routine diagnostic and laboratory tests;
3. It has a medical staff that is supervised full-time by a *physician*, or, at his or her direction, by a *nurse midwife*, and that includes a registered nurse at all times when patients are in the *facility*;
4. It has all the medical equipment necessary to properly treat potential *emergencies* of the mother and child;
5. It has a written agreement with a local *hospital* for the immediate transfer of a patient in the event of a complication;
6. It maintains a medical record for each patient; and
7. It expects to discharge or transfer to a *hospital*, each patient within 48 hours of the delivery.

Brand Name Drug or ***Brand Name*** means a *Prescription Drug* that has been given a *brand name* or trade name by its manufacturer and is advertised and sold under that name or is classified as such by national pharmaceutical database companies.

Calendar Year is the period beginning on the initial *effective date* of this *contract* and ending December 31 of that year. For each following year it is the period from January 1 through December 31.

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 healthcare benefits available to a *member*. *Case management* is instituted at the sole option of *us* when mutually agreed to by the *member* and the *member's physician*.

Chronic Health Conditions mean those conditions in which the patient's condition is either stabilized at a functional level or progressively deteriorating to the point where the *health professional* has determined that active *short-term* health treatment will not result in any reasonable expectation for improvement.

Claims means invoices or other standard billing documents containing details of health care services provided to a Member that a *provider* of health care services submits for payment, or that a Member submits to *us* for reimbursement.

Claims Forms means any document supplied by an insurer to an insured, claimant or other person that the insured, claimant or other person is required to complete and submit in support of a *claim* for benefits.

Coinsurance means the percent of a Covered Charge that the Member m*us*t pay for *covered services and supplies*. *Coinsurance* amounts are shown in the *Schedule of Benefits*. For example, *coinsurance* may be shown as 20%. This means that 20% of *covered expenses* are paid by the Member and 80% are paid by *us*. Not all *covered services* have *coinsurance*.

Complications of Pregnancy means:

- When pregnancy is not terminated: conditions whose diagnoses are distinct from pregnancy but are adversely affected by or caused by pregnancy, such as *acute* nephritis, nephrosis, cardiac decompensation, missed abortion; disease of the following body systems - vascular, hemopoietic, nervo*us*, endocrine, toxemia (pre-eclampsia);
- When pregnancy is terminated: non-elective caesarian section, ectopic pregnancy that is terminated, or spontaneo*us* termination of pregnancy that occurs during a period of gestation when a viable birth is not possible. Viable birth means that the fet*us* has reached a stage that will permit it to live outside the uter*us* and is capable of living outside the uter*us*;
- *Complications of Pregnancy* do not include multiple births, preterm labor, false labor, occasional spotting, *physician* prescribed rest during the period of pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy that do not constitute a nosologically distinct complication of pregnancy.

Concurrent Review means the examination of ongoing medical care by *us* to determine the Medically Necessity, appropriateness, and level of care.

Congenital Anomaly or ***Congenital Defect*** means a defective development or formation of a part of the body which is determined to have been present at the time of birth.

Contract or ***Policy*** when *italicized*, means this *contract* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

Contracted Rate means the rate that *network providers* are allowed to charge *you*, based on a contract between *us* and such *provider*. *Covered expenses* for services provided by a *network provider* will be based on the *contracted rate*.

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

Cosmetic or ***Cosmetic Surgery*** means surgical procedures, including plastic surgery or other treatment that *we* determines to be directed toward preserving, altering or enhancing appearance, whether or not for emotional or psychological reasons.

Cost sharing means the *deductible amount*, *copayment amount* and *coinsurance* that *you* pay for *covered services.* The *cost sharing* amount that *you* are required to pay for each type of Covered Service is listed in the Schedule of Benefits.

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

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

Coverage means health care services and treatments which are covered under this *Policy*.

Covered Expenses means expenses for *medically necessary covered services and supplies*. Expenses in excess of Eligible Expenses, will not be considered *covered expenses* under the *Policy*.

Covered Service(s) **and** ***Supplies*** means those *medically necessary* services, supplies or benefits that are payable or eligible for reimbursement under this *Policy*, including any amendments hereto subject to any benefit limitations, or maximums under this *Policy* and/or performed by *providers* within the scope of their practice. The fact that a *network provider* may prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it a Covered Service.

Crisis means a change or alteration in a patient's condition which is responsible for dysfunction, anxiety, pain, depression or a danger to self or others.

Custodial Care means provision of room and board, nursing care (excluding skilled nursing care), and personal care designated to assist an individual who in the opinion of *our* Medical Director has reached the maximum level of recovery. *Custodial care* also includes rest cures, respite care, and home care that is or can be performed by *family members* or non-medical personnel.

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

If *you* are a covered Member in a family of two or more Members, *you* will satisfy *your deductible amount* when:

1. *You* satisfy *Your* individual *deductible amount*; or
2. *Your* family satisfies the family *deductible amount* for the *calendar year.*

If *you* satisfy *your* individual *deductible amount,* each of the other *members* of *your* family are still responsible for the *deductible* until the family *deductible amount* is satisfied for the *calendar year.*

The *deductible amount* does not include any *copayment amounts.* Not all services are subject to the *deductible*.

Dependent means a lawful spo*use*, *eligible child*, by blood or law, who is under the age of 26 as of the date of adoption or placement for adoption. The term *dependent* does not include a person who is a Member's

natural child for whom legal rights have been given up through adoption, or a grandchild of the Member for whom the Member does not have court ordered permanent guardianship or *cus*tody.

Drug Usage Guidelines means criteria and clinical treatment recommendations that are developed and approved by *our* Pharmacy and Therapeutics Committees for *us*e in evaluating requests for medications that require *approval* for coverage.

Drugs or ***Prescription Drugs*** means any of the following:

- A federal legend Drug (a medication that is required by the U.S. Food, Drug and Cosmetic Act to include a label that reads: "Caution: Federal law prohibits dispensing without a prescription");
- A *drug* that requires a prescription under state law but not under federal law;
- A compound *drug* that has more than one ingredient, at least one of which the ingredients must be a federal legend *drug* or a *drug* that requires a prescription under state law.

Durable Medical Equipment or ***DME*** means durable items or appliances which:

- Serves a medical purpose rather than convenience and or comfort (its reason for existing is to fulfill a medical need, and it is not *us*eful to anyone in the absence of *illness* or *injury*);
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities;
- Can withstand repeated *us*e;
- Is appropriate for *us*e in a home setting.

Effective Date means the applicable date Coverage under this *contract* became effective.

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 child placed with *you* for adoption; or
4. 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* mu*s*t 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 or ***Allowable 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* and a network exception (as defined below) exists, 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 amount accepted by *non-network provider* (not to exceed the provider's 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. A "network exception" occurs when *you* receive *covered service* from a *non-network provider* either because there is no *network provider* accessible or available

that can provide such services to *you* timely, or *we* determine it is in *your* best interest to receive care from a *non-network provider*.

b When a *covered service* is received from a *non-network provider* as approved or authorized by *us* that is *not* the result of an *emergency* and for which a network exception does not exist, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the provider as payment in full (*you* will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the provider with *us*, the *eligible service expense* is the greater of (1) the amount that would be paid under Medicare, or (2) the contracted amount paid to *network providers* for the *covered service*. If there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts. *You* may be billed for the difference between the amount paid and the provider's charge.

Emergency or ***Emergent*** means a condition or *illness* which, if not immediately diagnosed and treated would result in extended or permanent physical or psychiatric impairment or loss of life, and requires the Member to seek immediate medical or psychiatric attention necessary for the relief of *acute* pain, repair of *accidental injury*, initial treatment of infection, or the relief of *illness*.

Emergency Services means health care services that are provided to a Member in a licensed medical *facility* by a *provider* after the recent onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the patient's health;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

Emergency services do not include *us*e of a *hospital* Emergency Room or other *emergency* medical *facility* for routine services, follow-up or continuing care, unless *authorized* by the *Primary Care Physician* or *us*.

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 *Us*e Disorder *services*, including behavioral health treatment, *Prescription drugs*, Rehabilitative and *habilitative services* and devices, Laboratory services, Preventive and wellness services, and chronic disease management and pediatric services, including oral and vision care. *Essential Health Benefits* provided within this *contract* are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum.

Exacerbation means a flare-up of an existing *illness* or *injury*.

Experimental, Unproved or Investigational Procedures means medical, surgical or psychiatric procedures, treatments, supplies or pharmacological regimes not generally accepted by the medical community associated with Heath Net. This includes procedures, services, equipment, devices or supplies which are in a testing state or in field trials on animals or humans, or do not have required final federal regulatory approval for commercial distribution for the specific indications and methods of *us*e assessed, or are not in accordance with generally accepted standards of medical practice, or have not yet been shown to be consistently effective for the diagnosis or treatment of a Member's condition.

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.

Facility or ***Facilities*** means institutions operating pursuant to state and/or federal statutes and regulations which are primarily engaged in providing *short-term* medical care and treatment of sick and injured persons. *Facility* also includes licensed institutions that provide diagnosis on an *outpatient* basis.

Family Member means a spouse, child, brother, sister, parent or grandparent of the Member, or a spouse's *family member* if applicable.

Family Unit means *you* and *your dependents* covered under the *Policy*.

Federally Facilitated Marketplace or ***Health Insurance Marketplace*****,** means a resource where individuals, families, and small b*us*inesses can learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The *Federally Facilitated Marketplace* also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the *Federally Facilitated Marketplace*, and information about other programs, including *Medicaid* and the Children's Health Insurance Program (CHIP). The *Federally Facilitated Marketplace* encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. In some states, the *Federally Facilitated Marketplace* is run by the state. In others it is run by the federal government.

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

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

Generic Drug or ***Generic*** means a *drug* product, containing identical active ingredients to the *brand name* product, which the FDA has determined to be therapeutically equivalent to the original *brand name* product and classified as such by national pharmaceutical database companies.

Grace Period means a period of 31 days following the Premium due date during which premium payments may be paid without a lapse in Coverage, or otherwise stated under the *grace period* provision in the Provisions for Coverage section of this *Policy*.

Habilitative Services means services 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 and devices for people with disabilities in a variety of *inpatient* or *outpatient* settings.

Health Plan means the benefits described in this *Policy* and provided by *us*.

Health Professional means a health care *provider* who is appropriately licensed, certified or otherwise qualified to deliver health services pursuant to state law and providing services within the scope of their license, and who has contracted with *us* to render *medical services* to *our* Members.

Home Health (Care) Agency means an agency or organization that is duly licensed by the appropriate licensing authority to provide skilled nursing services and other therapeutic services in the state or locality in which it is located, and operating in the scope of its license.

Home Health Care means medical care provided by a *network provider* from an approved *Home Health Care Agency* which is provided on an interim basis, or in lieu of hospitalization.

Hospice Care or ***Hospice Care Services*** means a program of care that is approved by *us* and which focuses on a palliative rather than a curative treatment for Members who have a life expectancy of 6 months or less.

Hospital means an institution operated pursuant to state or federal statutes and regulations and primarily engaged in providing medical care, psychiatric care, substance abuse diagnosis and treatment, and treatment of sick and injured persons through medical and diagnostic procedures.

Hospital Services means those *medically necessary* services for registered *inpatients* which are customarily rendered in an Acute Care General *Hospital*, or psychiatric specialty *hospital*, and prescribed or directed by a *network physician*.

Illness means a bodily sickness or disease, including Complication of Pregnancy, but not *mental illness*. All *illnesses* that are due to the same or a related cause or causes will be one *illness.*

Injury means an *accidental* bodily *injury* that is caused directly and independently of all other causes by an *accident*.

Inpatient means a person has been assigned to a bed in a *hospital*, Hospice or *Skilled Nursing Facility*, and a charge for room and board is made.

Intensive Care Unit (ICU) means a separate part of a *hospital* which meets all of the following tests:

1. It provides treatment to patients in critical condition;
2. It continuously provides special nursing care or observation by trained and qualified personnel;
3. It provides life-saving equipment.

Intermittent means nursing services (including services separated in time, such as two hours in the morning and two hours in the evening) that do not exceed a total of four hours in any twenty four hour period.

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.

Loss means an event for which benefits are payable to a *member* under this *contract*. *Expenses* incurred prior to this *contract*'s *effective date* are not covered, however, *expenses* incurred beginning on the *effective date* of insurance under this *contract* are covered.

Maintenance or ***Maintenance Care*** means services and supplies that are provided solely to maintain a condition at the level to which it has been restored or stabilized and from which level no significant practical improvement can be expected as determined by *us*.

Maximum out-of-pocket amount is the sum of the *deductible* amount, *prescription drug deductible amount* (if applicable), *copayment amount* and *coinsurance percentage* of *covered expenses*, as shown in the *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, Ambetter from Arizona 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. Both the individual and the family *maximum out-of-pocket amounts* are shown in the *Schedule* of Benefits.

For family coverage, the family *maximum-out-of pocket* amount can be met with the combination of any covered person's *eligible service expense*. A covered person's *maximum out-of-pocket* will not exceed the individual *maximum out-of-pocket* amount.

If *you* are a covered *member* in a family of two or more *members*, *you* will satisfy *your maximum out-of-pocket* when:

1. *You* satisfy *your* individual *maximum out-of-pocket;* or
2. *Your* family satisfies the family *maximum out-of-pocket* amount for the *calendar year*.

If *you* satisfy *your* individual *maximum out-of-pocket, you* will not pay any more *cost sharing* for the remainder of the *calendar year*, but any other eligible *members* in *your* family must continue to pay *cost sharing* until the family *maximum out-of-pocket* is met for the *calendar year*.

Medicaid means the program of medical coverage provided by the states under Title XIX of the Social Security Act, as amended by Public Law 89-97, including any amendments which may be enacted in the future.

Medical Services means those professional services of a *physician* and allied *health professionals*, including medical, surgical, diagnostic, and therapeutic services which are described in the section titled *De-*

scription of Benefits, and which are performed, prescribed or directed by a *network physician* within the scope of their license.

Medically Necessary or ***Medical Necessity*** means health care services that a *physician*, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an *illness*, *injury*, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's *illness*, *injury* or disease; and
- Not primarily for the convenience of the patient, *physician*, or other health care *provider*, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's *illness*, *injury* or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of *physicians* practicing in relevant clinical areas and any other relevant factors.

The fact that a *provider* may prescribe, order, recommend or approve a treatment, service, supply or medicine does not in itself make the treatment, service, supply or medicine *medically necessary* as defined in this *Policy*. The terms *medically necessary*, *medically indicated*, and *medical necessity* may be used interchangeably throughout this document.

Member means any person enrolled under this *Policy*, including *you, your* spouse or *eligible child*, for whom Premium payment has been received and accepted by *our* Accounts Receivable Department.

Mental disorder or ***Mental illness*** means those conditions classified as "mental disorders" in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, or the most recent edition of the International Classification of Diseases, Tenth Revision (ICD-10).

Mental Health Services means all services (including *hospital* stays) provided by psychiatrists, psychologists, or other mental health *providers*, including but not limited to, social workers and psychiatric nurses, that meet medical criteria and are specifically stated as being covered herein.

Morbid Obesity means any of the following:

- A weight of at least two (2) times the ideal weight for frame, age, height, and gender pursuant to the National Institutes of Health (NIH) BMI
- BMI of greater than or equal to 35kg/m2 with one or more high risk co-morbidities.

Negotiated Rate means the rate that a *provider* has agreed to accept as payment in full for a Covered Charge.

Network means any *physician* group practice or organization that has entered into a written agreement with *us* for the provision of *medical services* to *members* under this *Policy*. *Our* agreement with a *network* may terminate, and the *member* may be required to select another *network*, *Primary Care Physician* or other *network provider* to be primarily responsible for providing and coordinating a *member's medical services*.

Network Chiropractor means an individual who is a licensed Doctor of Chiropractic and who is under contract with the designated Chiropractic *provider* as shown in the *Schedule of Benefits* to provide chiropractic services to *members* of this *Health Plan*.

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

Network Hospital means a *hospital* which has an agreement with *us* to provide *hospital services* to *members* covered under this *Policy*.

Network Pharmacy means a pharmacy that has contracted with *us* to dispense covered pharmaceutical services to *members* of this Health Plan.

Network Physician means a *physician* who has entered into an agreement, or on whose behalf an agreement has been entered into, with *us* to provide *medical services* to *members* covered under this *Policy*.

Network Provider(s) means any person or entity that has entered into a contract with Ambetter from Health Net to provide *covered services* to *members* enrolled under this *Policy* including but not limited to, *hospitals*, specialty *hospitals*, *Urgent Care facilities*, *physicians*, pharmacies, laboratories and other *health professionals* within *our* Service Area.

Newborn Period means the first 31 days following birth.

Non-Network Chiropractor means a chiropractor who is not under contract with the designated Chiropractic *provider* as shown in the *Schedule of Benefits*, to treat *members* through an arrangement with the Health Plan.

Non-Network Provider means any *provider* that has not contracted with Ambetter from Health Net to provide health care services to *members* covered under this *Policy*.

Nurse Midwife means a person who:

- Is licensed as, or certified to practice as a *nurse midwife* and is practicing within the scope of that license; or
- Is licensed by a board of nurses as a registered nurse (R.N.) and
- Has completed a program for the preparation of *nurse midwife* that is approved by the state in which the person is practicing.

Orthotics means rigid or semi-rigid devices used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured body part.

Outpatient means *covered services* provided on other than an *inpatient* basis. An *outpatient* visit is generally defined as 3 hours or less. 4 hours would be counted as one-fourth of an *inpatient* day, and 5 through 8 hours would be counted as one-half of an *inpatient* day. Anything over 8 hours would count as a full *inpatient* day.

Over-the-Counter means any item, supply or medication which can be purchased or obtained from a vendor without a prescription.

Payor(s) means an insurer, health maintenance organization, no-fault liability insurer, self-insurer, governmental program, or other entity or program that provides or pays for health care benefits.

Physician means a person who:

- Is recognized and licensed under the laws of the state where treatment is received as qualified to treat the type of *injury* or *illness* for which a *claim* is made; and
- Is practicing within the scope of his or her license; and
- Is a duly licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.), or other *health professional* not specifically named in this *Policy* for whom reimbursement is mandated under applicable Arizona or federal law, when licensed in the state where services are received.

Plan means any health care entity which provides health care service and treatment Coverage.

Primary Care Physician (PCP) means the *network physician* who provides, arranges and coordinates a *member's* health care. *PCP's* include *physicians* in the areas of family practice, general practice, internal medicine, and pediatrics. Upon enrollment, a *member* selects a *physician* from the list of *network physicians*. Obstetricians may also act as a *member's PCP* during pregnancy and postpartum periods. *Members* do not need to contact *us* to change their *PCP* to an obstetrician during pregnancy and postpartum periods. *Members* can self-refer to a *physician*, *health professional*, or *provider* that specialize in obstetrics or gynecology at any time.

A *PCP's* relationship with *us* may terminate, and the *member* may be required to select another *PCP* who will be responsible for providing and coordinating a *member's* total health care. A list of *PCP's*, their locations and hours of operation, is available to each *member* upon enrollment. Such lists shall be revised periodically as deemed necessary by *us*.

Private Duty Nursing means services that are provided in a *hospital* room from a Registered Nurse (RN) or a Licensed Practical Nurse (LPN), in accordance with a *physician's* care plan. *Private Duty Nursing* services are provided by a licensed nurse that is prescribed on an *intermittent* basis while the patient is *inpatient* in a *medically necessary acute* hospitalization.

Prosthetic, Prosthetic Devices or ***Prostheses*** means the mechanical devices that replace the function of an internal or external body part by an artificial substitute which may or may not be surgically implanted. These include mastectomy bras/camisoles.

Provider means a licensed *physician*, dentist, podiatrist, psychologist, *hospital* or *facility*, Pharmacy, nurse practitioner, social worker holding a masters degree in social work or other licensed medical practitioner practicing within the lawful scope of his or her license.

Providers also include other health care professionals not specifically named in this Certificate for whom reimbursement is mandated under applicable Arizona or federal law, when licensed by the state in which services are delivered, and performing services within the scope of their license.

Qualified Autism Service Provider means either of the following: (1) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the

National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified. (2) A person licensed as a *physician* and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist and who designs, supervises, or provides treatment for pervasive developmental disorder or autism spectrum disorders, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Providers employ and supervise qualified autism service professionals and paraprofessionals who provide behavioral health treatment and implement services for pervasive developmental disorder or autism spectrum disorders pursuant to the treatment plan developed and approved by the *Qualified Autism Service Provider*.

- A qualified autism service professional is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism spectrum disorders and is approved.
- A qualified autism service paraprofessional is an unlicensed and uncertified individual who has adequate education, training, and experience as certified by the *Qualified Autism Service Provider*.

Qualified Travel Expenditures means transportation, room and board costs incurred while obtaining *authorized covered services* outside the Service Area in cases where it has been determined by *us* that the *authorized covered services* are not available in the Service Area. Refer to the Organ Transplant Travel Services benefit under the Description of Benefits in this *Policy* for a description of *covered services* and limitations that apply.

Referral means the request made through the *Primary Care Physician* for *authorization* of specialty services or equipment on behalf of a *member*. In order for services to be covered, *referrals* must be approved by *us*, prior to *member* receiving specialty services.

Residential Substance Abuse Treatment Program means a program conducted within a Residential Treatment Center that specializes in the evaluation and treatment of drug addiction and alcoholism. Its goal is to teach addicts and alcoholics how to achieve and maintain long term abstinence.

Residential Treatment Center means a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. *We* require that all contracted *Residential Treatment Centers* must be appropriately licensed by their state in order to provide residential treatment services.

Routine Care includes, but is not limited to, conditions such as colds, flu, sore throats, superficial injuries, minor infections, follow-up care and preventive care. Treatment for these conditions should be sought from a *Primary Care Physician* and are not considered *emergency services*.

Schedule of Benefits means a summary of the *deductible*, *copayment*, *coinsurance*, *maximum out-of-pocket* and other limits that apply when *you* receive *covered services and supplies*.

Short-Term means the reasonable period of time when significant, documented, continued improvement in a *membe*r's condition can be expected in a predictable period of time. A "predictable period of time" means the length of time as submitted by the *network provider* and Approved by *us* or *our* designee.

Skilled Nursing Facility means an *extended care facility* which is licensed as a *Skilled Nursing Facility* and operated in accordance with the laws of the state in which the *member* resides in.

Sound Natural Teeth means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

Special Enrollment Period means individuals who experience certain qualifying events can enroll in, or change enrollment outside of the initial and annual open enrollment periods. The *effective date* of coverage depends on the Qualifying Events.

Specialist or ***Specialist Physician*** means a duly licensed *network physician*, other than the *Primary Care Physician*, under contract with Ambetter to provide professional services when *authorized*.

Specialized or ***Custom Durable Medical Equipment, Prosthetics or Orthotics*** means equipment, *prosthetics* or *orthotics* not generally considered to be the standard of care for a specific condition, disease or *injury* or made for a specific purpose not considered *medically necessary* as determined by *us*.

Support Devices are the rigid or semi-rigid devices, such as braces or splints, used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured body part.

Total Disability or ***Totally Disabled*** means a *member* who is prevented because of *injury* or disease from performing his/her regular or customary occupational duties and is not engaged in any work or other gainful activity for compensation or profit. For a *dependent*, a person who is prevented because of *injury* or disease from engaging in substantially all of the normal activities of a person of like age and gender in good health, including any work or other gainful activity for compensation or profit.

Urgent Care means services provided for the relief of *acute* pain, initial treatment of *acute* infection, or a medical condition that requires medical attention, but a brief time lapse before care is obtained does not endanger life or permanent health. Urgent conditions include, but are not limited to, minor sprains, fractures, pain, heat exha*us*tion, and breathing difficulties, other than those of sudden onset and persistent severity

Urgent Care Facility means any licensed *facility* that provides *physician* services for the immediate treatment only of an *injury* or disease.

Utilization Management or ***Utilization Review*** is a prior, concurrent and retrospective process whereby requests for service under this Plan are reviewed:

- For *medical necessity* and appropriateness;
- For verification that the service is a covered benefit;
- For verification where benefits have a predetermined limit that *medical services* have not been exceeded, or are being appropriately applied, or applied in a timely manner consistent with the diagnosis and treatment; and
- For verification that the *member* is eligible for services under this *Policy*.

Utilization review performed prior to receipt of services does not guarantee Coverage if other plan provisions are not satisfied (for example, *member* is not eligible on date of service).

We, ***Us***, or ***Our*** means Ambetter from Health Net of Arizona, Inc. or its designee.

You or ***Your*** means a *member* who is covered under this *Policy*.

ACCESS TO CARE

UNDERSTANDING WHAT IS COVERED
Each *member* covered under this *health plan* is entitled to receive the benefits and services described in this *policy*. With the exception of preventive services, all *covered services* must be *medically necessary*. *Covered services* must be obtained from Ambetter's contracted *network providers*, except for *emergency services* as defined in this *policy*.

Ambetter reserves the right to modify benefits under this Agreement at any time. Written notice of benefit changes, including modifications to preventive benefits, will be provided to Enrollees at least 60 days prior to the *effective date* of the change.

Although *we* encourage *you* to read this entire document to familiarize yourself with *your* health *coverage*, the following sections should be reviewed immediately upon enrollment:

- *Prior-Authorization.* This section identifies which services and supplies require *our* review before *you* receive them in order to receive the maximum reimbursement possible under *Your* Health Plan.

- *Description of Benefits*. This section describes the services and treatments, which are covered under *Your* Health Plan, including general health physicals.

- *Limitations and Exclusions*. This section identifies services and treatments that are not covered under *your* Health Plan, or are limited in coverage.

PARTICIPATING PROVIDERS
Ambetter has contracted with *physicians*, *hospitals*, *facilities* and other *health professionals* to provide *medical services* and treatments to *members* covered under this Health Plan. These *physicians*, *hospitals* and *facilities* are referred to as *network providers*.

YOUR PRIMARY CARE PHYSICIAN
Every *member* has the option to have a *Primary Care Physician*. These *Primary Care Physicians* are sometimes referred to as a *PCP*. *Your PCP* is the person who will provide and coordinate *medical services* and treatments *you* may require while covered by *us*. At some time, *you* may need to see a *physician* who is a *specialist*. *Your Primary Care Physician* will refer *you* to one. If *you* are hospitalized, *your Primary Care Physician* will coordinate the care and services *you* need with the *hospital* and any other *physicians* who may be involved.

During regular office hours:
- Call the office and identify Yourself as an Ambetter *member*
- *Your Primary Care Physician* has a staff that can schedule an appointment or help answer *your* medical questions.

After regular office hours:

- Call the office and identify Yourself as an Ambetter *member*
- Describe the medical condition *You* are experiencing
- Your *Primary Care Physician's* office will have *your physician*, or another *health professional*, contact *you*. He or she will discuss the *illness* or *injury* in question and give *you* direction. Each case is different. *You* may receive advice over the telephone or *you* may be asked to come into the office. In *emergency* or urgent situations, *you* may be directed to the nearest *Emergency* or *Urgent Care facility*.
- Always remember that *you* can call *your Primary Care Physician's* office 24 hours a day. *You* do not have to wait for regular office hours to obtain medical advice.

Each *member* of a family who is covered by *us* has the right to select their own *Primary Care Physician*. This means that a parent who desires to have a *Primary Care Physician* close to their office may select a different *Primary Care Physician* for their children closer to home. In addition, *you* may select a *physician* specializing in pediatrics as the *Primary Care Physician* for each child, even if the pediatric *physician* is not identified as a *Primary Care Physician*. Please make sure that *you* have selected a *Primary Care Physician* for yourself and each of *your dependents* that are enrolled under this Health Plan. Until *you* make this selection, Health Net will designate one for *you*. Refer to *our* Provider Directory for a list of *Primary Care Physicians*, or *you* can visit *our* website at www.ambetterhealthnet.com. If *you* need help in choosing a *Primary Care Physician*, call *us* Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

CHANGING PRIMARY CARE PHYSICIANS

You, and each of *your* enrolled *dependents*, may select a new *Primary Care Physician* by contacting Member Services *us*. The following are some general guidelines to follow if *you* need to change *your Primary Care Physician*:

- *You* can switch *your PCP* only one time per month.
- If we receive *your* request for a transfer on or before the 15th day of the month, the transfer will occur on the first day of the following month. For example, if *your* request is received March 12th, *your PCP* transfer will be effective April 1st.
- If we receive *your* request for transfer on or after the 16th day of the month, the transfer will occur on the first day of the second following month. For example, if *your* request is received March 17th, *your PCP* transfer will be effective May 1st.
- If *your* new *PCP* is not affiliated with *your* existing *network*, *you* must renew all existing *authorizations* through *your* new *Primary Care Physician*. Please refer to Network Affiliations below.
- A *network* may request that a *member* be transferred out of their *network* for cause.

NETWORK AFFILIATIONS

Your Primary Care Physician and other *health professionals* have contracted with *us* to provide *medical services* and treatments to *you*. They have contracted either individually, or through a group of Providers called a *network*. If *your Primary Care Physician* is affiliated with a *network*, *you* may be required to obtain services from *specialists* and other *providers* who belong to that *network*. If *you* are unsure whether *your Primary Care Physician* is affiliated with a *network*, check *our* Provider Directory or call Member Services.

If *your network provider* is removed from the *network* without cause, *you* will be notified of the change. If *you* are in active course of treatment, *you* may request continued treatment with the Provider until the treatment is complete, or for 90 days, whichever is shorter, at In-Network *cost sharing* rates.

Active course of treatment is defined as:

- An ongoing course of treatment for a life-threatening condition;
- An ongoing course of treatment for serious *acute* condition;
- The second or third trimester of pregnancy; or
- An ongoing course of treatment for a health condition for which a treating Provider attests that discontinuing care by that Provider would worsen the condition or interfere with anticipated outcomes.

SPECIALIST PHYSICIANS
Specialist physicians may also be part of *your network*. If *your physicians* determines that *you* need care from a *specialist*, *your Primary Care Physician* will refer *you* to the appropriate *specialist* within *our network*.

Services and treatments by Specialists are covered when a *referral* is approved. Always remember that *your Primary Care Physician* is the person responsible for coordinating *your* care and will refer *you* to an appropriate *specialist* when it is *medically necessary*. *We* do allow a few exceptions to the *referral* requirements, as described in the *Description of Benefits* section of this *Policy*.

You are not required to obtain a *referral* from a *Primary Care Physician* (*PCP*) or *us* to obtain *covered services* from a *specialist* within the *network*. We recommend that *you* work with *your PCP* to determine which *specialist* is right for *you*. *Your PCP* knows *your* medical history best and is the most appropriate person to help coordinate all of *your* health care needs.

Self-referrals under this *health plan* are limited to In-Network *specialists*. Services received from a *non-network provider* may be denied by *us* and *you* may be held financially responsible for the charges.

AVAILABILITY OF PROVIDERS
We cannot guarantee the continued availability of any particular *physician*, *network*, *facility* or other *health professional*. Consequently, if a *Primary Care Physician* terminates his or her relationship with *us*, *you* will be required to select another *Primary Care Physician*, who will be responsible for providing and coordinating *your* total health care. ***Covered Services* must be obtained from *network providers* who are under contract with Ambetter from Health Net at the time *Medical Services* are received.**

REFERRAL REQUIRED FOR MAXIMUM BENEFITS
You do not need a *referral* from *your network Primary Care Physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a *referral* from *your network Primary Care Physician* for benefits to be payable under *Your policy* or benefits payable under this *Policy* may be reduced. Please refer to the *Schedule of Benefits*.

COST SHARING FEATURES

COST SHARING FEATURES
We will pay benefits for *covered services* as described in the Schedule of Benefits and the *covered services* sections of this *contract*. All benefits we pay will be subject to all conditions, limitations, and *cost sharing* features of this *contract*. *Cost sharing* means that *you* participate or share in the cost of *your* healthcare services by paying *deductible amounts*, *copayments* and *coinsurance* for some *covered services*. For example, *you* may need to pay a *copayment* or *coinsurance* amount when *you* visit *your physician* or are admitted into the *hospital*. The *copayment* or *coinsurance* required for each type of service as well as *your deductible* is listed in *your* Schedule of Benefits.

COPAYMENTS / COINSURANCE
This *health plan* requires the *member* to pay a *copayment* and/or *coinsurance* when receiving *covered services*. *Copayments* and *coinsurance* are the *member's* responsibility and are due to the Provider at the time *covered services* are received. Appointments made by a *member* that are not cancelled 24 hours in advance are also subject to *copayment*, *coinsurance* and/or a late cancellation fee. The *copayment* and *coinsurance* amounts applicable to this *health plan* are described in the attached *Schedule of Benefits*. If *you* need another copy of the Schedule, please call Member Services.

INDIVIDUAL AND FAMILY DEDUCTIBLES
The Individual and Family *calendar year deductible amounts* are shown in the *Schedule of Benefits*. The *calendar year deductible* applies to the medical and *outpatient prescription drug* benefits. Once *your* payment for medical and *outpatient prescription drug covered expenses* equals the *deductible amount*, the medical and *outpatient prescription drug* benefits will become payable by *us*, subject to any additional *copayment* or *coinsurance* as described in the *Schedule of Benefits*.

Each *member* m*us*t satisfy the individual *deductible* each Year, if the Family *deductible* has not been previo*us*ly satisfied in that Year, before benefits are payable by *us*. Once the Family *deductible* is met; no further Individual *deductible* for *members* of the *family unit* will have to be satisfied during the Year for benefits to be payable by *us*. Any exceptions will be shown in the *Schedule of Benefits*. All amounts applied toward the Individual *deductible* for each *member* in a *family unit* will accumulate to satisfy the Family *deductible*. Once the Family *deductible* is met, no further individual *deductibles* for covered *members* in the *family unit* will have to be satisfied during the *calendar year*.

MAXIMUM OUT-OF-POCKET
This is the total dollar amount that a *member* or *family unit* is required to pay for *covered services* during any given *calendar year maximum out-of-pockets* are determined for *covered services* only and do not apply to any *medical services* or treatments that are not *covered services*.

Individual
The *covered expenses* that *you* pay, except as described below, are counted towards the Individual *maximum out-of-pocket*. The amount of the *maximum out-of-pocket* is listed in the *Schedule of Benefits*. When this amount is reached for an individual in a Year, *covered expenses*, except as described below, are payable at 100% for the remainder of the Year.

Family
The *covered expenses* that covered *members* in a *family unit* pay, except as described below, are counted towards the Family *maximum out-of-pocket*. The amount of the *maximum out-of-pocket* is listed in the *Schedule of Benefits*. When this individual *maximum out-of-pocket* is reached for an individual in a Family in a Year, *covered expenses* for that individual, except as described below, are payable at 100% for the remainder of the Year.

The following are not counted toward the Individual or Family *maximum out-of-pocket* and will not be paid at 100% once the *maximum out-of-pocket* is met. They will be subject to the *copayment*, *coinsurance* and/or Deductible as shown in the *Schedule of Benefits*:

1. Any percentage of *covered expenses* that a *member* must pay due to failure to follow any requirements of *Prior Authorization*.
2. Limitations and exclusions.

Refer to *your* Schedule of Benefits for *Coinsurance* Percentage and Other Limitations
The amount payable will be subject to:
1. Any specific benefit limits stated in the *contract*;
2. A determination of *eligible expenses*; and
3. Any reduction for expenses incurred at a *non-network provider*. Please refer to the information 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 expenses* for those services or supplies. In addition to the *deductible amount* and *coinsurance percentage*, *you* are responsible for the difference between the *eligible expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible expense* will not apply to *your deductible amount* or *maximum out-of-pocket*.

PRIOR AUTHORIZATION

Please read this entire provision carefully. If you are unsure whether a service or treatment requires Prior Authorization, please call Ambetter from Health Net or have your Provider call Ambetter from Health Net for additional information.

Selected services and treatments that are covered under *your health plan* require *approval* before *you* receive them in order for them to be covered by *us*. This *approval* is referred to as *Prior Authorization.* This means that even though a service or treatment may be a covered benefit, *Prior Authorization* must be obtained before the service or treatment can be received. Even those services that are determined to be *medically necessary* by *us* must have *Prior Authorization* in order to be covered. *Physicians* and *networks* cannot deny a service or treatment for failure to obtain *Prior Authorization*. Only *we* can deny *coverage* for *medical services* for failure to obtain *Prior Authorization*. Questions concerning *Prior Authorization* can be directed to *your Primary Care Physician*, or *you* can call Member Services. *Prior Authorization* does not guarantee *coverage*.

Circumstances in which the service will not be covered include, but are not limited to:

- Other plan provisions are not satisfied (for example, the *member* is not enrolled or eligible for service on the date the service is received or the service is not a Covered Benefit);
- Fraudulent, materially erroneous or incomplete information is submitted; or
- A material change in the *member's* health condition occurs between the date that the *Prior Authorization* was provided and the date of the treatment that makes the proposed treatment no longer *medically necessary* for such *member*.

In the event that Company certifies the *medical necessity* of a course of treatment limited by number, time period or otherwise, a request for treatment beyond the certified course of treatment shall be deemed to be a new request.

As a general rule, please remember that, except for Emergency Services, all *Medical Services* and treatments must be provided through the direct coordination of the *Primary Care Physician* and received within the Service Area. If they are not, *your Health Plan* may not cover these services.

The following services or supplies require *prior authorization*:

1. *Hospital confinement*s;
2. *Hospital confinement* as the result of a *medical emergency;*
3. *Hospital confinement* for *psychiatric care;*
4. *Outpatient surgeries* and *major diagnostic tests*;
5. *All inpatient services;*
6. *Extended care facility* confinements;
7. *Rehabilitation facility* confinements;
8. *Skilled Nursing Facility* confinements;
9. *Transplants;* and
10. Chemotherapy, *specialty drugs* and biotech medications.

Prior Authorization requests must be received by telephone, efax, or provider web 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. Within 24 hours of an admission to an *inpatient* behavioral health or substance ab*us*e treatment admission. No *prior authorization* shall be required for *short-term inpatient* withdrawal management and clinical stabilization services for up to 24 hours.
5. At least 5 days prior to the start of *home healthcare*.

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

Except for *medical emergencies*, *prior authorization* m*us*t be obtained before services are rendered or expenses are *incurred*.

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 or denied.

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* m*us*t 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.*

WHAT TO DO IN AN EMERGENCY
If *you* are faced with a medical or psychiatric *emergency*, call 911 or go to the Emergency room.

Some examples of *emergencies* include:

- *Acute* chest pain
- Severe burns
- Profuse bleeding
- Suspected poisoning
- Severe allergic reaction

Non-Emergency and *Routine Care* provided in an Emergency Facility is not covered and the *member* will be financially responsible for any Emergency room expenses incurred for such non-Emergency services. *Routine Care* is described in the *Definitions* section of this booklet.

Please refer to the *Description of Benefits* section of this booklet for a complete definition of an *emergency*. This section will also tell *you* what is covered and what *your* responsibility is to notify *us* of an *emergency* situation.

URGENT CARE SITUATIONS
Urgent Care Situations include cases of high fevers, severe vomiting, sprains, fractures, or other injuries. In such cases, call *your Primary Care Physician*. The *PCP's* office is available 24 hours a day, 7 days a week by telephone. *You* will be given direction on how to obtain care for *your* condition. All follow-up and continuing care must be provided or arranged through *your Primary Care Physician* in order to be covered by *us*.

UTILIZATION MANAGEMENT
Ambetter reviews certain requests for medical procedures, specialty consultations and hospitalizations to determine whether the treatment is *medically necessary*, as determined by *us*, and to verify that the services are covered under this Health Plan. The determination of the reviewer or professional review organization is not a substitute for the independent judgment of the treating *physician* as to the course of treatment. ***Utilization Management* decisions do not prevent treatment or hospitalization but do determine whether or how the treatment or hospitalization is covered by Ambetter.**

HOSPITAL BASED PROVIDERS
When receiving care at an Ambetter *network hospital* it is possible that some *hospital*-based providers (for example, anesthesiologists, radiologists, pathologists) may not be under contract with Ambetter as *network providers*. These providers may bill *you* for the difference between Ambetter's allowed amount and the providers billed charge – this is known as "*balance billing*". *We* encourage *you* to inquire about the providers who will be treating *you* before *you* begin *your* treatment, so *you* can understand their participation stat*us* with Ambetter.

ALTHOUGH HEALTHCARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO *YOU* AT A HEALTHCARE FACILITY THAT IS A *MEMBER* OF THE PROVIDER *NETWORK* USED BY AMBETTER, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY *PHYSICIANS* AND OTHER MEDICAL PRACTITIONERS WHO ARE NOT *MEMBERS* OF THAT *NETWORK*. *YOU* MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY AMBETTER.

MEDICAL EXPENSE BENEFITS

Covered Services must be furnished in connection with *medically necessary* diagnosis and treatment of an *illness* or *injury* (other than *covered expenses* for preventive care services, if applicable). If *we* determines that a service or supply or medication is not *medically necessary*, *you* will be responsible for payment of that service, supply or medication.

Covered Services are subject to the *copayment* and/or *coinsurance* amounts, Lifetime Maximum Benefits, Maximum Benefits per Year, and other limitations as described in the enclosed Schedule of Benefits, and to all other provisions of this *Policy*.

Coverage under the *Policy* is limited to the most effective and efficient level of care and type of service or supply that is consistent with professionally recognized standards of medical practice, as determined by *us*.

HOW COVERED EXPENSES ARE DETERMINED

Ambetter from Health Net will pay for *covered expenses you* incur under this Health Plan. As described below, *covered expenses* are based on the amount *we* will allow for *covered services you* receive from each type of Provider, not necessarily the amount a *physician* or other Provider bills for the service or supply. Other limitations on *covered expenses* may apply. See *Description of Benefits, Limitations and Exclusions*, and *your Schedule of Benefits* sections for specific benefit limitations, maximums, *Prior Authorization* requirements and surgery payment policies that limit the amount *we* pay for certain *covered services*.

HOSPITAL INPATIENT AND OUTPATIENT SERVICES

Emergency Services and the minimum *hospital* stay requirements for maternity do not require *Prior Authorization*. All other *hospital services*, whether *inpatient* or *outpatient*, must be *Prior Authorized*.

Any *member* who receives *emergency services* must contact his or her *Primary Care Physician* within 48 hours of admission, or as soon thereafter as is reasonably possible.

INPATIENT SERVICES

Covered Services include:

- Semiprivate room and board (private room when *medically necessary*)
- *Hospital* and *physician* services, including supplies and consultation
- *ICU*, CCU and other special care units
- Operating room and related *facilities*
- Medications and biologicals ◆
- Diagnostic services, including x-ray and laboratory
- General nursing care (special duty nursing when *medically necessary* and *authorized*)
- Oxygen and related services
- Inhalation treatment
- *Private Duty Nursing* is provided under the direction of a *physician*-signed order, specific to an individualized plan of care implemented by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). It does not include non-skilled care, *custodial care*, respite care, or care during surgical procedures, including anesthesia■.

- Surgical procedures■, including anesthesia
- Meals, including special diets when *medically necessary*
- Administration of whole blood and blood plasma
- *Physician* visits
- Radiation therapy and chemotherapy
- *Medically necessary* services of a *physician*, including office visits and consultations, *hospital* and *Skilled Nursing Facility* visits, and visits to *your* home.

◆ Based on national billing guidelines for Providers, multiple surgical procedures performed during a single operative session will be reviewed to determine appropriate benefit payment levels. In general, secondary and tertiary procedures are reimbursed at lower levels.

■ Medications and biologicals are covered while confined in the *hospital*. Take home medications from an *inpatient facility* are not covered. Medications prescribed following discharge from an *inpatient facility* will be covered through the *outpatient prescription drug* benefit. Any restrictions or limitations, including Formulary restrictions, of the *outpatient prescription drug* Benefit will apply.

All covered surgical procedures, including the services of the surgeon or *specialist*, assistant surgeon and anesthetist or anesthesiologist, together with preoperative and postoperative care are covered.

Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry; it also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema and at least two external postoperative *prostheses*, including mastectomy bras/camisoles, subject to all of the terms and conditions of the *policy*.

Payment of benefits for surgical expenses will be reduced as set forth herein if *Prior Authorization* is not obtained for the surgery.

OUTPATIENT SERVICES INCLUDING AMBULATORY SURGICAL FACILITIES

Covered Services include:

- Medications and biologicals ◆
- Surgical procedures, including anesthesia
- Therapeutic services including chemotherapy, radiation therapy and inhalation treatment
- Diagnostic services, including x-ray and laboratory ▲
- Oxygen and related services
- *Emergency Services* as defined in this *Policy*
- Administration of whole blood and blood plasma

◆ Medications and biologicals are covered while confined in the *hospital*. Take home medications from an *inpatient facility* are not covered. Medications prescribed following discharge from an *outpatient facility* will be covered through the *outpatient prescription drug* benefit. Any restrictions or limitations, including Formulary restrictions, of the *outpatient prescription drug* benefit will apply.

▲ The *copayment* or *coinsurance* for diagnostic services, including x-ray and laboratory services, obtained at an *outpatient* Surgery or *Ambulatory Surgical Facility* may be different than the *copayment* or *coinsurance* if the service is obtained at a *physician's* office. Please refer to the Schedule of Benefits to determine *your copayment* or *coinsurance* amount.

OFFICE VISITS
Covered Services include:

- Office visits to *physicians*, including *specialists* ◆
- Treatment for an *injury* or *illness*
- Allergy testing, antigen administration, desensitization treatment, allergy treatment and allergen administration in accordance with accepted medical practice, or as otherwise determined to be *medically necessary*.
- An annual flu shot, when received in the office of the *Primary Care Physician* at a *network pharmacy* participating in the vaccine network, or at an affiliated flu shot clinic sponsored by the *member's Primary Care Physician*.

Note additional services (including but not limited to x-rays, lab testing) done during an office visit may be subjected to additional *cost sharing* for those services above the office visit *cost sharing*.

Additionally, some *providers* (e.g. *Primary Care Physicians*, *specialist*) may operate out of a *hospital* or *facility*, note that applicable *copayments* or *coinsurance* for an office visit may not cover any charges that the *hospital* or *facility* bills and *you* may be responsible for these charges.

◆ *Specialist* visits may require the *member* to obtain a *referral* through the *Primary Care Physician*, referring *provider* or Ambetter.

ROUTINE PHYSICAL EXAMINATION
One routine physical examination (including psychological examination or drug screening) per *calendar year*, requested by the *member* without medical condition indications is covered. However, filling out forms related to the physical exam is not covered.

A routine examination is one that is not otherwise medically indicated or *physician* directed and is obtained for the purposes of checking a *member's* general health in the absence of symptoms or other non-preventive purposes. Examples include examinations taken to obtain employment, or examinations administered at the request of a third party, such as a school, camp, or sports organization.

PREVENTIVE CARE, EXAMINATIONS AND IMMUNIZATIONS
The *coverage* described below shall be consistent with the requirements of the Affordable Care Act Whether something is preventive it is determined by the diagnosis submitted by the *provider*. Preventive Care can include the following:

- Preventive health exams
- Well baby care for 47 months
- Immunizations
- Hearing screening ◆
- Vision screening ◆
- Gynecological examinations
- Flu shot
- Womens Preventive Services include, but are not limited to:
  - Screening for gestational diabetes,
  - Human papillomavirus (HPV) DNA testing for women 30 years and older,
  - Sexually-transmitted infection counseling;
  - Human immunodeficiency virus (HIV) screening and counseling;

- FDA-approved contraception methods and sterilization procedures, and contraceptive counseling for women with reproductive capacity;
- Breastfeeding support, supplies, and counseling (One breast pump and the necessary supplies to operate it (as prescribed by *your physician*) will be covered for each pregnancy at no cost to the *member*. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. Breast pumps can be obtained by contacting Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180); and
- Interpersonal and domestic violence screening and counseling.

- Colorectal Cancer Screening: Screening colonoscopy and sigmoidoscopy procedures, related including anesthesia services (for the purposes of colorectal cancer screening) will be covered under the preventive care services. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an *outpatient facility* require the *copayment* or *coinsurance* applicable for *outpatient facility* services.
- Preventive Lab and X-ray
- Counseling Services: counseling for alcohol misuse, smoking cessation, breastfeeding/lactation, depression/psychological, genetic, healthy diet/ nutrition, obesity in adults and children, preventative medication, sexually transmitted infections, and tobacco use.
- Preventive medications (including smoking cessation medications)

◆ Hearing screening and vision screenings are covered at no cost as a preventive service. *Referrals* to *specialists* for *injury* or *illness* related conditions are covered at the Office Visit *copayment* and/or *coinsurance* indicated.

Additional recommended preventive care services include the following:

- United State Preventive Services Task Force (*US*PSTF)recommended type "A" and "B" services
- Immunizations and inoculations as recommended by the Advisory Committee on immunization Practices of the Center for Disease Control (CDC)
- Pediatric preventive care and screening, as supported by the Health Resources and Services Administration (HRSA) guidelines
- Women's health care services as supported by HRSA guidelines
- Other USPSTF recommendations for breast cancer screening, mammography and prevention.
- Prostate specific antigen (PSA) screening and digital rectal examination (DRE) are covered annually if the following criteria is met:
  1. If *you* are under 40 years of age and are at high risk because of any of the following:
     a. Family history (i.e., multiple first-degree relatives diagnosed at an early age)
     b. African-American race
     c. Previous borderline PSA levels
  2. If *you* are age 40 and older.

Preventive physical examinations and immunizations will be covered when obtained from or through *your Primary Care Physician* according to the guidelines and policies adopted by *us*. This Agreement will not provide less than the minimum benefits required by state and federal laws. Additional examinations and immunizations will be covered if determined to be *medically necessary* by *your Primary Care Physician*, subject to the Limitations and Exclusions listed herein.

If a service is considered diagnostic or non-preventive care, your plan *copayment*, *coinsurance* and *deductible* will apply. It's important to know what type of service you're getting. If a diagnostic or non-preventive service is performed during the same healthcare visit as a preventive service, you may have *copayment* and *coinsurance* charges.

AMBULANCE SERVICES

Covered Services include:

- *Emergency* transportation from the site of an *accidental* injury or *acute illness* to the nearest *facility* capable of providing appropriate treatment.
- Air or water evacuation will be considered *medically necessary* if the patient's condition is of an *emergency* nature, the location where the *accidental injury* and/or *illness* occurred is inaccessible by ground vehicles, or transport by ground *ambulance* would be detrimental to the patient's health.
- Transportation between *hospitals* or between a *hospital* and skilled nursing or rehabilitation *facility* when *authorized* by Ambetter from Health Net.

Covered Services for ground, water or air *ambulance* travel must be provided by a duly licensed vehicle specifically designed and equipped for transporting the sick and/or injured.

Covered Services do not include transportation for non-*emergent* treatment unless *authorized* by *us*.

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* (for example- transport van, taxi).

AUTISM SPECTRUM DISORDER
Subject to the terms and conditions of the *Policy* (EOC), *we* cover the diagnosis and treatment of Autism Spectrum Disorders (ASD) as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. ASD includes:

- Autistic disorder;
- Asperger's syndrome and
- Pervasive development disorder; not otherwise specified

If multiple services are provided on the same day by different *providers*, a separate *copayment* will apply to each *provider*. Visit limit is included within 60 visit *outpatient* rehabilitation benefit.

If multiple services are provided on the same day by different *providers* as separate *copayment* and/or *coinsurance* will apply to each *provider*.

Medically necessary behavioral therapy will be provided when prescribed by the *member's* treating *network Provider* in accordance with an approved *behavioral therapy* treatment plan. *Covered Services* must be provided or supervised by a licensed or certified *network provider*.

Professional services for behavioral health treatment, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a *member* diagnosed with pervasive developmental disorder or autism.

The treatment must be prescribed by a licensed *physician* or developed by a licensed psychologist, and must be provided under a documented treatment plan prescribed, developed and approved by a *Qualified Autism Service Provider* providing treatment to the *member* for whom the treatment plan was developed. The treatment must be administered by the *Qualified Autism Service Provider*, or by qualified autism service professionals and paraprofessionals who are supervised and employed by the treating *Qualified Autism Service Provider*.

A licensed *physician* or licensed psychologist must establish the diagnosis of pervasive development disorder or autism spectrum disorders. The treatment plan must have measurable goals over a specific timeline that is developed and approved by the *Qualified Autism Service Provider* for the specific patient being treated, and must be reviewed by the *Qualified Autism Service Provider* at least once every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.

The *Qualified Autism Service Provider* must submit updated treatment plans to *us* for continued behavioral health treatment beyond the initial six months and at ongoing intervals of no more than six-months thereafter. The updated treatment plan m*us*t include documented evidence that progress is being made toward the goals set forth in the initial treatment plan.

We may deny *coverage* for continued treatment if the requirements above are not met or if ongoing efficacy of the treatment is not demonstrated.

BARIATRIC SURGERY AND RELATED COVERED SERVICES
Covered Services include *inpatient* bariatric surgery and gastric bypass surgery, including lap banding adjustments, for the treatment of Morbid Obesity that are *medically necessary* and not *experimental or investigational*. These *covered services* must be *authorized* by *us* in accordance with *our* evidence based criteria for this intervention contained in *our* Medical Policy on Bariatric Surgery which can be found at www.ambetterhealthnet.com under the medical policies link.

In addition, the following criteria must be met:

1. The patient must have a body-mass index (BMI) ≥35.2.
2. Have at least one co-morbidity related to obesity.
3. Previously unsuccessful with medical treatment for obesity.

The following medical information must be documented in the patient's medical record:

- Active participation within the last two years in one *physician* supervised weight-management program for a minimum of six months without significant gaps.
- The weight-management program must include monthly documentation of all of the following components:
  a. Weight
  b. Current dietary program
  c. Physical activity (e.g., exercise program)

We apply evidence based medicine, and in as much develops national medical policies to define *medical necessity*. At a minimum, the following procedures are included: laparoscopic sleeve gastrectomy (LSG), open roux-en-y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB), open biliopancreatic diversion with duodenal switch (BPD/DS) and laparoscopic biliopancreatic diversion with duodenal switch (BDP/DS).

- Surgery will be considered *medically necessary* for adolescents ages 13 to 18 years of age when criteria is met.

In addition, the procedure must be performed at a *network facility*.

CHIROPRACTIC SERVICES

Members may self-refer to a Doctor of Chiropractic contracted with the designated Chiropractic *provider* as shown in the *Schedule of Benefits*. Coverage is provided for 20 visits for *medically necessary* Chiropractic Services.

Covered Services are those within the scope of chiropractic care which are necessary to help *members* achieve the physical state enjoyed before an *illness* or *injury*, and which are determined to be *medically necessary* and generally furnished for the diagnosis and/or treatment of neuromusculoskeletal conditions associated with an *injury* or *illness*, including:

- Chiropractic manipulations, adjustments and physiotherapy
- Diagnostic radiological services generally provided by *network chiropractors*
- Examination and treatment for the *aggravation* of an *illness* or *injury*
- Examination and treatment for the *exacerbation* of an *illness* or *injury*

CLINICAL TRIALS

Routine patient costs for items and services furnished in connection with participation in approved clinical trials are covered as required by state and federal law. *We* will not exclude, limit or impose special conditions on such coverage and *we* will not include provisions that discriminate against an individual on the basis of the individual's participation in an approved clinical trial. *You* must pay any *deductibles, copayments* or *coinsurance* that apply to the items and services whether or not *you* receive the items and services in connection with Clinical Trial. *Prior Authorization* is required. The following provisions apply:

- Routine patient costs include all items and services consistent with the coverage provided in the

plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include:

a. The cost of Investigational services, drugs or devices, whether or not *you* receive the items and services in connection with clinical trial;
b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
c. The cost of any non-health services;
d. The cost of managing research; or
e. Items or services that would not otherwise be covered

- Approved clinical trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening condition and is approved or funded by at least one of the following:
    a. One of the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, or the Centers for Medicare and Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs;
    b. Supported by a cooperative group or center of any of the entities described above;
    c. The FDA in the form of an investigational new drug application or if the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
    d. A qualified research entity that meets the criteria of the NIH for grant eligibility; or
    e. A panel of qualified recognized experts in clinical research within academic health institutions in this state.

For purposes of clinical trials, the term "life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

DENTAL SERVICES

Emergent dental services under this *health plan* are limited to services and treatments which are received in connection with an *injury* or as a direct result from a *congenital defect*.

Services are covered under the *medical* portion of *your health plan* when it is determined to be related to a medical condition or *injury* and are determined to be *medically necessary* and include:

- Services to treat *sound natural teeth* damaged as a result of an *accident*.
- The reduction or manipulation of fractures of facial bones including the jawbone and supporting tissues due to an *accidental injury*.
- Oral surgery for the excision of lesions, cysts, or tumors.
- Reconstruction or repair of the palate or cleft lip.
- Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) are covered if approved as *medically necessary*

Dental Services under this *health plan* do not include:

- Preventive, routine or general care of teeth or dental structures.
- Extraction of impacted or abscessed teeth and services related to malocclus*us*ion or malposition of the teeth or jaw.
- *Accidental injury* to the teeth or gums caused by chewing.
- Dental splints, dental implants, dental *prostheses* or dentures.

- General anesthesia unless required due to hazardous medical conditions
- Dental applications and orthodontia

DIABETIC CARE MANAGEMENT
The following is covered in relation to *members* who have been diagnosed with diabetes:

- Diabetes *outpatient* self-management training and education, including a wellness health coaching program that guides an individual to change unhealthy behaviors and adopt positive lifestyle changes in order to promote the life-long practice of good health behavior. Refer to the Schedule of Benefits Health under Health/Education and Disease Management for applicable *copayment*, *coinsurance* or *deductibles*.
- Supplies and equipment related to Diabetes Management as described in the *outpatient prescription drug* Benefit and Diabetic Supplies, Equipment and Devices provision of this section.
- Nutritional counseling services are covered and not subject to the lifetime limit as shown in the Nutritional Counseling Services provision of this section.
- Routine foot care in connection with the treatment of diabetes.
- Self-referral once each Year to an eye care *specialist* for the purpose of receiving an eye exam for the detection of eye disease as described in the Vision Services provision of this section.

DIABETIC EQUIPMENT, SUPPLIES AND DEVICES
Diabetic supplies are covered when *medically necessary*. The following are specific requirements for *coverage*:

- Diabetic supplies must have a written prescription from a *network provider*, when *medically necessary*.
- Refills are covered only when *authorized* by a *network provider*, when *medically necessary*.
- Covered supplies and equipment must be obtained from a *network provider* unless otherwise *authorized* by *us*.
- Plan approved standard blood glucose monitors are covered for both insulin-dependent and non-insulin dependent *members* when necessary for medical management as determined by *us* in consultation with *your physician*. Blood glucose monitors require a written prescription from a *physician* and must be obtained at a *network pharmacy*.
- Plan approved blood glucose monitors for the legally blind are covered when *medically necessary* and the *member* has been diagnosed with diabetes. Blood glucose monitors require a written prescription from a *physician* and must be obtained at a *network pharmacy*.

The following are examples of Diabetic supplies that are covered when they meet the specific requirements for *coverage*:

- Glucose test strips
- Visual reading testing strips
- Urine testing strips
- Insulin aids (when *medically necessary*)
- Glucagon (requires *Prior Authorization*)
- Drawing up devices (syringes) and monitors for the visually impaired
- Preferred Insulin vials/pens
- Insulin cartridges for both the legally blind and the able seeing (requires *Prior Authorization*)
- Insulin and insulin pumps
- Lancets and Automatic lancing devices
- Spacers and holding chambers for inhaled medications

- Inhalers (nasal or oral)

The following diabetic equipment is covered under the Durable Equipment Benefit:
- Podiatric appliances necessitated by a diabetic condition.
- Foot *orthotics* are covered for the treatment of diabetes.

DIALYSIS SERVICES
Covered Services include:
- Equipment, training, and medical supplies required for home peritoneal dialysis.
- *Maintenance* of dialysis equipment required for home peritoneal dialysis.
- Medical and *hospital services* for dialysis for renal disease, including *outpatient* settings. Hemodialysis for *chronic health conditions* are covered only when received at *facilities* within the Ambetter *network*.
- Out-of-Area dialysis treatments are covered when *authorized* by *us*.

DURABLE MEDICAL EQUIPMENT (DME), BRACES AND ORTHOTICS
Covered Services when *medically necessary*, and prescribed by *your physician*, include but are not limited to:
- Apnea monitors when *medically necessary*.
- Therapeutic oxygen and equipment for the administration of oxygen.
- Crutches, canes, walkers, and manual hospital beds are covered when determined to be *medically necessary*.
- If a *member* requires an electric or specialized wheelchair, then the *member* may receive reimbursement for the purchase price of a standard size manual wheelchair to *us*e towards the cost of the electric or specialized wheelchair in accordance with *our* rules and regulations. Electric or specialized wheelchairs are not a covered benefit under this Health Plan. This provision does not apply to leased wheelchairs.
- Medical supplies that are determined to be *medically necessary* to operate and/or maintain a covered prosthesis or item of *Durable Medical Equipment* are covered, subject to the limitations stated herein.
- Podiatric appliances are covered when such appliances are directly related to a diabetic condition.
- Peak flow meters are covered when prescribed by a *network physician* and plan *approved*.
- *DME* items must be obtained from a *network provider* of *DME* in order to be covered.
- *We* retain the right to determine if *DME* items shall be leased or purchased.
- A *member* may request specialized equipment but the extra cost associated with specialized equipment will be the responsibility of the *member*.
- Breastfeeding support, supplies and counseling as supported by Health Resource and Services Administration (HRSA) guidelines, are covered as preventive care listed under the "Preventive Care" section in the Schedule of Benefits.
- Repair and/or replacement of equipment or parts due to normal wear and tear is covered only when *medically necessary*.

We apply guidelines in assessing *medical necessity* for *coverage*.

Braces and Orthotics:

- *Coverage* is limited to rigid or semi-rigid devices used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured body part.
- *Coverage* is limited to therapeutic braces that are dispensed, prescribed and *authorized* through a *network provider*, which cannot be reused by another person, and are necessary for a *member* to engage in the activities of normal daily living.
- Replacement of braces is covered only when *medically necessary*, or results from normal wear and tear or a change in a *member's* medical condition such as physical growth.

Covered Services for Durable Medical Equipment, including Braces and *orthotics*, do not include:

- Exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses, or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, and hygienic equipment;
- Equipment for a patient in an institution that is ordinarily provided by an institution, such as wheelchairs, hospital beds and oxygen tents, unless these items have been *authorized* by *us*;
- More than one device designed to provide essentially the same functional assistance;
- Deluxe, electric, *specialized or custom durable medical equipment*, *prosthetics* or *orthotics*, model upgrades, and portable equipment requested for travel;
- Transcutaneous Electrical Nerve Stimulation (TENS) units;
- Pulse oximeters;
- ThAIRapy® vests, except when *our* medical criteria is met;
- Scooters and other power operated vehicles;
- Repair or replacement of equipment or parts due to misuse and/or abuse, adjustment, model upgrades and duplicates, except as stated elsewhere in this *Policy*;
- *Over-the-counter* braces and other *DME* devices, except as specifically listed as being covered herein;
- Prophylactic braces, except as specifically listed as being covered herein;
- Braces used primarily for sports activities;
- Warning devices, stethoscopes, blood pressure cuffs, or other types of apparatus used for diagnosis or monitoring, except as specifically listed as being covered herein;
- Foot *orthotics* which are not an integral part of a leg brace. Examples include shoe lifts, arch *support devices*, orthopedic and/or corrective shoes. (This exclusion does not apply to the *coverage* of special shoes and inserts for certain patients with diabetes, or any of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation). Please refer to *your* diabetic benefits for further specification.) Repair or replacement of deluxe, electric, *specialized or custom durable medical equipment*, *prosthetics* or *orthotics*, model upgrades, and portable equipment for travel; and
- Communication devices (speech generating devices) and/or training to *us*e such devices.

EMERGENCY SERVICES
If *you* are faced with a medical or psychiatric Emergency, call 911 or go to the Emergency room.

Emergency/Emergent is defined as a condition or *illness* which, if not immediately diagnosed and treated:

- Would result in extended or permanent physical or psychiatric impairment or loss of life; and
- Requires the *member* to seek immediate medical or psychiatric attention necessary for the relief of *acute* pain, repair of *accidental injury*, initial treatment of infection or the relief of *illness*.

Examples of *emergency* include a severe burn, profuse bleeding, a suspected heart attack, sudden *acute* pain in the chest, a severe allergic reaction or suspected poisoning.

Emergency Services means health care services that are provided to a *member* in a licensed *hospital* Emergency Facility by a *provider* after the recent onset of a medical or psychiatric condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical or psychiatric attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the patient's health;
- Serious impairment to bodily functions;
- Serious disfigurement of the patient;
- Serious dysfunction of any bodily organ or part; and
- In case of a behavioral condition, placing the health of the patient or other persons in serious jeopardy.

Emergency Services **do not include use of a Hospital Emergency room or other *emergency* medical *facility* for routine *medical services*, or follow-up or continuing care. The *member* will be financially responsible for any Emergency room expenses for any non-Emergency Services as determined by Ambetter.**

Emergency Services are provided 24 hours a day, 7 days a week, worldwide.
*Emergency Services***:**

- Do not require *Prior Authorization*.
- Include an initial medical or psychiatric screening examination and any immediate treatments or services to stabilize a condition. Additional treatments or services may be retrospectively reviewed for *medical necessity*.
- Require the *member* to notify the *Primary Care Physician* within 48 hours after *emergency services* are provided by a *non-network provider*, or as soon thereafter as is medically possible. If admitted to a non-contracted *inpatient facility*, *we* may transfer the *member* to a *network hospital* for continued care if it is medically appropriate.
- Require the *member* to provide full details, including medical or psychiatric records of *emergency services* rendered by a *non-network provider*, if requested by this Health Plan. Costs associated with *emergency services* will be reimbursed only after *we* receive and review the *emergency* medical or psychiatric records and determine that such services were *medically necessary*.

Emergency Services Outside the Service Area
Members who sustain an *injury* or become ill while away from the Service Area may receive *emergency services* as provided herein. Benefits are limited to conditions that require immediate attention.

Emergency Services outside of the Service Area do not include:

- Elective or specialized care.
- Non-emergent, continuing, routine or follow-up care.

FAMILY PLANNING SERVICES (CONTRACEPTION AND VOLUNTARY STERILIZATION)

Covered family planning services include:

- Medical history;
- Physical examination;
- Related laboratory tests;
- Medical supervision in accordance with generally accepted medical practice;
- Information and counseling on contraception;
- Implanted/injected contraceptives; and
- After appropriate counseling, *medical services* connected with surgical therapies (vasectomy or tubal ligation).
- Abortions that are determined to be *medically necessary* to save the life of the member, or due to rape, incest, life-endangerment, or necessary to avert substantial and irreversible impairment of a major bodily function of the member having the abortion are covered.
- Diagnostic genetic testing when determined to be *medically necessary* and *Prior Authorized* by *us*
- Tubal ligations
- Vasectomies
- Contraceptive methods and contraceptive counseling, as supported by the Health Resources and Services Administration (HRSA) guidelines, are covered under the Preventive Care benefit. FDA-approved contraceptive drugs and devices are covered through a *network pharmacy* under the *outpatient prescription drug* Benefit.

Contraceptives

Refer to the *Schedule of Benefits* and *outpatient prescription drug* benefit for a description of *covered services*.

Genetic Testing

- Diagnostic genetic testing is covered when determined to be *medically necessary* and *authorized* by *us*.
- Genetic testing, amniocentesis, ultrasound, or any other procedure required solely for the purposes of determining the gender of a fetus is not covered.

Sterilization Procedures

- Sterilization procedures, including tubal ligation and vasectomy are covered. *Copayment* and/or *coinsurance* will correspond to the charge associated with the *facility* in which services are received. Preventive sterilization of females is covered under the Preventive Care benefit, subject to the applicable *copayment* and/or *coinsurance* listed under the Preventive Care section.

FERTILITY PRESERVATION

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

Exclusions and Limitations: Services and supplies for gamete or embryo storage, use of frozen gamete or embryos to achieve future conception, pre-implantation genetic diagnosis, donor egg, sperm or embryos and/ or gestational carriers.

GENDER REASSIGNMENT SERVICES
Medically necessary gender reassignment services, including, but not limited to, psychotherapy, pre-surgical and post-surgical hormone therapy, and surgical services (e.g., such as genital surgery and mastectomy), for the treatment of gender dysphoria and/or gender identity disorder are covered.

Services not *medically necessary* for the treatment of gender dysphoria and/or gender identity disorder are not covered. Gender reassignment surgical services must be performed by a qualified *provider* in conjunction with gender transformation treatment reassignment surgery or a documented gender reassignment surgery treatment plan.

HABILITATIVE SERVICES
Coverage for *habilitative services* and/ or therapy is limited to *medically necessary* services that help a person keep, learn, or improve skills and functioning for daily living, when provided by a Plan contracted *physician*, licensed physical, speech or occupational therapist or other contracted *provider*, acting within the scope of his or her license, to treat physical and mental health conditions, subject to any required *authorization* from the Plan or the *member's* Physician Group. 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. The services must be based on a treatment plan *authorized*, as required by the Plan or the *member's* Physician Group.

Examples of health care services that are not habilitative include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, *custodial care*, or education services of any kind, including, but not limited to, vocational training**.**

HEARING SERVICES
Covered Services include:
- Hearing screenings to determine the presence of hearing loss and/or to diagnose and treat a suspected disease or *injury* to the ear.
- Treatment for a disease or *injury* to the ear.
- Hearing aid services are limited to one hearing aid per ear, per *calendar year*.
- Cochlear implants when *medically necessary*.
- New or replacement hearing aids no longer under warranty (*Prior Authorization* required).
- Cleaning or repair.
- Batteries for cochlear implants.

Covered Services do not include:

- Hearing aid batteries (except those for cochlear implants) and chargers are not covered.

HOME HEALTH CARE SERVICES

Home Health Care is covered when a *member* is physically unable to obtain necessary medical care on an *outpatient* basis, would otherwise be confined as an *inpatient*, and is under the care of a *network physician*, subject to the following:

- *Covered Services* must be provided by an Ambetter contracted *Home Health Care Agency*.
- *Coverage* is limited to *medically necessary* patient care pursuant to guidelines, frequency, duration and level *authorized* by *us*.
- *Covered Services* include nursing care under the supervision of a registered nurse and rehabilitative therapy and/or IV therapy, when prescribed, *authorized* or directed by the *Primary Care Physician* and *authorized* by *us*.
- *Covered Services* are limited to part-time and *intermittent* patient care that is determined to be *medically necessary*.
- *Home Health Care* Services for infusion must be obtained in *your physician's* office, home setting, or an infusion center. *We* have contracts with preferred *providers* who specialize in home infusion services and may be able to offer these services in an alternate setting.

Covered Services do not include:

- Housekeeping services
- Services of a person who resides in the *member's* home
- *Custodial care*, rest cures, respite care and home care that is or can be performed by *family members* or non-medical personnel
- Services of a person who qualifies as a *family member*
- Services of an unlicensed person.

HOSPICE CARE SERVICES

Members who are diagnosed as having an *illness* giving them a life expectancy of 6 months or less, may request *hospice care*. All *hospice care* must be provided by a licensed Participating hospice and include *Inpatient* and *outpatient* care related to the terminal condition and family counseling. *Hospice care* will continue only while the *member* is under the direct and active medical supervision of a *network physician* for a condition that necessitates *hospice care* will require *prior authorization* by *us*.

Hospice Care providers must be able to provide:

- Licensed nursing care
- Medical supplies
- Medications
- *Physician* services
- *Short-term inpatient* care
- Appliances
- Homemaker services
- Care for *acute* and chronic symptom management
- Care for pain control
- Physical and/or respiratory therapy
- Medical social services
- Home health services

- Services of volunteers
- Services of a psychologist, social worker or family counselor for individual and family counseling.

A *member* who elects *hospice care* is not entitled to services and supplies for curative or life prolonging procedures during the time that the Hospice election is in effect. A *member* may revoke a Hospice election at any time.

INFERTILITY SERVICES
Services associated with infertility are limited to diagnostic services rendered for infertility evaluation. Refer to the *Limitations and Exclusions* section of this *Policy* for more detail on non-covered infertility services.

MAMMOGRAMS
Mammograms are *covered services* as listed below, when requested by a *network physician*. A suggested schedule for preventive care is listed below:

- One baseline mammogram for members between the ages of 35 and 39 years.
- One mammogram each year for members who are 40 years of age or older or more frequently if recommended by a *network physician*.
- Such other mammography screenings as are determined to be *medically necessary* for a member considered "at risk," as determined by *us* and requested by a *network physician*.

MATERNITY CARE SERVICES
Medically necessary services and supplies furnished in connection with pregnancy and childbirth are covered.

Covered Services include:

- Prenatal and post-partum care
- Birth services, including delivery room, *birthing centers*, anesthesia and surgical procedures
- Ultrasound
- Anesthesia
- Injectables
- Special procedures such as caesarian section
- Prenatal diagnostic procedures in case of high risk pregnancy or as otherwise *medically necessary*
- *Complications of Pregnancy* as defined in this *Policy*
- X-ray and laboratory services
- Surgical procedures
- Breastfeeding support, supplies, and counseling as supported by the Health Resources and Services Administration (HRSA) guidelines, are covered under the Preventive Care benefit listed in the Schedule of Benefits.
- Prenatal screenings as outlined in the USPSTF recommendations A&B are covered under the Preventive Care benefit listed in the Schedule of Benefits.
- Diagnostic genetic testing is covered when determined to be *medically necessary* and *authorized* through the *physician*, or referring *specialist*.

NOTE: The *member* must notify *us* within 31 days of the birth to designate a *Primary Care Physician* for the newborn and to obtain a *member* identification card.

Travel Outside of the Service Area
Expectant *members* who have reached 32 weeks gestation are encouraged to discuss any travel arrangements outside of the Service Area with their *Primary Care Physician*. Prenatal visits or elective care received outside of Ambetter's Service Area are not covered unless *authorized* by *us*. *Emergency services* received outside the Service Area are limited to conditions that require immediate attention.

Minimum Hospital Stay Requirements. *Hospital* length of stay for the mother and newborn following a covered delivery will be at the discretion of the treating *physician* in consultation with the mother. *Hospital* benefits for the mother and newborn will not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarian section, if ordered by the treating *physician*. *Providers* will not be required to obtain *Prior Authorization* for such lengths of stay. These provisions do not prohibit lengths of stay of less than the minimum otherwise required when the attending *physician*, in consultation with the mother, makes a decision for early discharge. ***Hospital* confinements that exceed the minimum stay requirements as described herein, will require Prior Authorization by *us*.**

Newborn Charges
Medically necessary services, including *hospital services*, are also provided for a newborn child of the *member* (including legally adopted newborn children and newborn children who have been placed for adoption with a *member*), immediately after birth. In addition, *medical services* for the newborn child shall be provided for the first 31 days following birth. **Continued Coverage beyond the first 31 days following birth is subject to the enrollment requirements and receipt by *us* of any required Premiums, if applicable.**

The expenses of the natural mother of any child legally adopted by the *member*, within 1 year of birth are covered provided that:

1. The *member* must be legally obligated to pay the costs of such birth;
2. The *member* r must pay all required *copayment* and/or *coinsurance* amounts for such care;
3. The *member* must otherwise be eligible for *coverage*;
4. The *member* notifies *us* of his or her acceptability to adopt within 60 days after a change in insurance policies, plans or companies.

In the event that the mother remains in the *hospital* beyond the minimum *hospital* stay requirements or is discharged from the hospital and the newborn child remains hospitalized or is readmitted, the *hospital* stay for the newborn child is subject to the applicable *copayment* and/or *coinsurance* in addition to the mother's *copayment* and/or *coinsurance*.

The *member* must notify *us* of the existence and extent of any *coverage* the natural mother may have. If the natural mother has maternity *coverage* under another Health Plan, those benefits will be primary. *Our* benefits will be secondary, if needed.

MEDICAL SUPPLIES
Medical Supplies are issued when *medically necessary*. *Covered Services* include:

- Casting materials.
- Surgical dressings only when provided under the supervision of a *Home Health Agency* and prescribed by the *Primary Care Physician*.
- Ostomy supplies and urinary catheters (are limited as defined by Medicare guidelines).

- Medical supplies necessary to operate a covered prosthesis or item of Durable Medical Equipment, subject to the limitations stated herein.
- Breastfeeding devices and supplies, as supported by Health Resources and Services Administration (HRSA) guidelines, are covered as preventive care listed under "Preventive Care" section in the Schedule of Benefits.
- Compression garments when used as treatment for Lymphedema

Covered Services are subject to the following Limitations and Exclusions:

- *We* apply medical supply quantity limits.
- Tube feeding supplies, food supplements and formulas provided in an ambulatory, *outpatient* or home setting are not covered. Medical supplies necessary to operate a non-covered item of *DME* or prosthesis are not covered.
- *Over-the-counter* dressings and soft goods, such as ace wraps, gauze, alcohol swabs and dressing, which are not provided in the *Primary Care Physician's* office or under the supervision of a participating *Home Health Agency* are not covered.
- Surgical dressings are limited to those provided under the supervision of a participating *Home Health Agency* and prescribed by the *Primary Care Physician*.

MENTAL HEALTH & SUBSTANCE USE DISORDER -INPATIENT AND OUTPATIENT SERVICES

Our behavioral health and substance use vendor oversees the delivery and oversight of covered behavioral health and substance use disorder services for Home State Health. *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 *our* behavioral health and substance use vendor's *provider network* and do not need a *referral* from *your PCP* in order to initiate treatment. *Deductible amounts*, *copayment* or *coinsurance* amounts and treatment limits for covered mental health and substance use disorder benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health 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, including pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association and the most current version of the International Statistical Classification of Diseases and Related Health Problems (ICD). Treatment is limited to services prescribed by *your physician* in accordance with a treatment plan.

When making *coverage* determinations, *our* behavioral health and substance *us*e vendor utilizes established level of care guidelines and *medical necessity* criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. Our behavioral health and substance use vendor utilizes "Interqual" criteria for mental health determinations and ASAM American Society of Addiction Medicine (ASAM) criteria for substance ab*us*e 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*, and *outpatient mental health* and/or substance use disorder *services* are as follows:

Inpatient Services
Covered Services Include:

- *Inpatient* Psychiatric Hospitalization.
- *Inpatient mental health services* must be received in a *network hospital*, specialty hospital or *facility*. Hospitalization will be subject to review proceedings by the designated behavioral health representative.
- *Inpatient* detoxification treatment.
- Observation.
- *Crisis* assessment/stabilization.
- *Inpatient* Rehabilitation.
- Electroshock and other convulsive therapy.

Voluntary and court-ordered residential substance abuse for mental health and substance abuse treatment.

Outpatient Services
Covered services include, but are not limited to:

- Traditional *outpatient* services, including treatment of conditions such as: anxiety or depression which interferes with daily functioning.
- Psychological and neuropsychological testing and assessment.
- Partial Hospitalization and Intensive *outpatient* Treatment Programs.
- Day Treatment.
- Electroshock and other convulsive therapy.
- *Outpatient* services for the purpose of monitoring drug therapy.
- *Outpatient* detoxification programs.
- Psychological and Neuropsychological testing and assessment.
- Medication management services.

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

NUTRITIONAL COUNSELING SERVICES
Nutritional evaluation and counseling from a *network provider* is covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to:

- Morbid obesity
- Diabetes
- Cardiovascular disease
- Hypertension
- Kidney disease
- Eating disorders
- Gastrointestinal disorders
- Food allergies
- Hyperlipidemia

All other services for the purpose of diet control and weight reduction are not covered unless required by a specifically identified condition of disease etiology. Services not covered include but not limited to:

- Intra oral wiring

- Gastric balloons
- Dietary formulae
- Hypnosis
- Cosmetics
- Health and beauty aids

ORAL AND MAXILLOFACIAL SURGERY
Covered under this benefit:
- The reduction or manipulation of an *acute* fracture of facial bones including the jawbone and supporting tissues due to an *accidental injury*
- Oral surgery for the excisions of lesions, cysts or tumors
- Reconstruction or repair of the palate or cleft lip

Not Covered:
- Any treatment for arthroplastic surgery
- Any services related to malocclusion or malposition of the teeth or jaw
- Oral implants and transplants

OUTPATIENT IMAGING AND TESTING SERVICES
Covered Services include:
- CT
- MRI/MRA
- PET/SPECT
- BEAM (Brain Electrical Activity Mapping)
- ECT (Emission Computerized Tomographam)

Copayments and *coinsurance* may be different depending on whether the services are received at a *physician's* office, or a *hospital*, *outpatient* Surgery Facility or *Ambulatory Surgical Facility*.

OUTPATIENT PRESCRIPTION DRUG BENEFIT
This benefit applies only to Prescription Drugs that are prescribed on an *outpatient* basis.
Preventive Pharmacy medications require a prescription and are limited to *prescription drugs* and *over-the-counter* medications that are determined to be preventive as recommended by the United States Preventive Services Task Force (USPSTF) A and B recommendations, as well as FDA approved *over-the-counter* contraceptives for women when prescribed by a *provider*. A listing of these medications may be identified at the following USPSTF website:
www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

SPECIFIC REQUIREMENTS FOR COVERAGE
The following provisions apply to this Prescription Drug Benefit:
- Prescriptions must be included on Ambetter's Formulary. For select *drugs*, *your* doctor must request *authorization*. Requests for these *drugs* are evaluated to determine if the established *approval* criteria are met.
- All *Prescription Drugs* must be obtained from a *network pharmacy*.
- Coverage is provided for *generic*, *brand*, non-preferred brand and *specialty drugs* included no the Ambetter Formulary.
- Participating retail and Specialty Pharmacies will dispense prescriptions for up to a 30 day supply.

- Mail Order prescriptions will be dispensed for up to a 90 day supply.
- Some medications may be dispensed in quantities less than those stated above due to prepackaging by the pharmaceutical manufacturer.
- Insulin, diabetic supplies and inhalers have quantity per *copayment* and/or *coinsurance* payment limitations other than 30 days.
- *You* will be financially liable for the cost of medications obtained after *you* are no longer eligible for *coverage* under this Health Plan.
- Non-Formulary (NF) *drugs* require *prior authorization* for *coverage*.
- *Prescription Drugs* that are routine patient costs provided to *members* participating in clinical trials are covered as required by state and federal law.
- Medications for weight loss may be covered with *Prior Authorization*.
- Medications for sexual dysfunction may have quantity per *copayment* limitations prescribed in the Formulary.

If a *drug* is not on the Drug Formulary and is not specifically excluded from *coverage*, *your* doctor can ask for an exception. To request an exception, *your* doctor can submit a *Prior Authorization* request along with a statement supporting the request. Requests for *Prior Authorization* may be submitted by telephone, mail, or facsimile (fax). If we approve an exception for a *drug* that is not on the formulary, the non-preferred brand tier (Tier 3) *copayment* applies. For a standard exception request, *we* will make a *coverage* determination no later than 72 hours following receipt of the request. If *you* are suffering from a condition that may seriously jeopardize *your* life, health, or ability to regain maximum function, or if *you* are undergoing a current course of treatment using a *drug* that is not on the Formulary, then *you*, *your* designee or *your* doctor can request an expedited review. Expedited requests for *Prior Authorization* will be processed within 24 hours after *our* receipt of the request and any additional information requested by *us* that is reasonably necessary to make a determination.

SPECIALTY PHARMACIES
As part of Our Specialty Pharmacy program, certain *drugs* are only available through a Specialty Pharmacy designated by *us*. *We* will contact *you* and *your physician* if a Specialty Pharmacy will now be dispensing a particular *drug* for *you*. *We* will work with *you*, *your physician* and the Specialty Pharmacy to coordinate services such as ordering, delivery and *copayment* collection.

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

Through our mail order pharmacy, you can order up to a 90-day supply of your maintenance *drug*. Refer to the Schedule of Benefits for the mail order *cost sharing* amount. Pharmacists dispense the *drugs* and then ship them through standard mail at no extra cost to you. Contact Member Services for more information on the mail order program.

COPAYMENTS/COINSURANCE AND QUANTITY LIMITATIONS
The *member* is required to pay a predetermined *copayment* and/or *coinsurance* for each prescription dispensed. Refer to the *Schedule of Benefits* to determine the applicable *copayment* and/or *coinsurance* under *your* Health Plan.

Cancer Treatment Medications
Patient administered cancer treatment medications, including medications that are orally administered or self-injected, require no higher *copayment*, *deductible* or *coinsurance* amount than cancer treatment medications that are injected or intravenously administered by a health care *provider*. Cancer treatment medications mean *prescription drugs* and biologics that are used to kill, slow or prevent the growth of cancerous cells.

Medication Synchronization
In accordance with state regulations, upon request, a *member* taking two or more chronic *prescription drugs* may ask a *network pharmacy* to synchronize refill dates so that *drugs* refilled at the same frequency may be refilled concurrently. This will allow the *copayments* to be prorated based on the synchronized days' supply. For questions about this process, please call Member Services at the number listed at the back of *your* ID Card.

Diabetic Pharmacy Benefit
Diabetic *medications and supplies* ❶ and the quantity per *copayment* limitations that apply include the following:

Quantity Limitations. The following quantity limitations apply to both retail pharmacy and mail order prescriptions. It should be noted that insulin, diabetic supplies and inhalers have quantity per *copayment* and/or *coinsurance* payment limitations in addition to the 30 day supply limitation.

Diabetic Supplies and Medications	*Quantity Limitations*
• Insulin (vials only)	Up to 2 vials per *copayment* and/or *coinsurance*
• Drawing up devices (syringes) and monitors for the visually impaired	Up to 100 per *copayment* and/or *coinsurance*
• Insulin cartridges for the legally blind and able seeing (requires *Prior Authorization*)	One commercial package per *copayment* and/or *coinsurance*
• Glucose test strips	Up to 100 per *copayment* and/or *coinsurance*
• Visual reading testing strips	Up to 100 per *copayment* and/or *coinsurance*
• Urine testing strips	Up to 100 per *copayment* and/or *coinsurance*
• Lancets	Up to 100 per *copayment* and/or *coinsurance*
• Automatic lancing devices	1 every 6 months per *copayment* and/or *coinsurance*
• Injection aids (when *medically necessary*)	1 every 6 months per *copayment* and/or *coinsurance*
• Glucagon (requires *Prior Authorization*)	1 per *copayment* and/or *coinsurance*
• Plan approved standard Blood glucose monitors are covered for both insulin-dependent and non-insulin-dependent *members* when necessary for medical management as determined by *us* in consultation with *your physician*. Blood glucose monitors require a written prescription from a *physician* and must be obtained at a *network pharmacy*.	Up to one per Year
• Plan approved blood glucose monitors for	Up to one per Year

the legally blind are covered when *medically necessary* and the *member* has been diagnosed with diabetes. Blood glucose monitors require a written prescription from a *physician* and must be obtained at a *network pharmacy*.

- Covered Diabetic medications and supplies, including oral agents, are subject to Ambetter's Formulary and are available to all *members* covered under this Health Plan. To access benefits, simply present *your member* identification card to a *network pharmacy* and pay the required *copayment* and/or *coinsurance* at the time the prescription is filled. *Our* Provider Directory includes a list of contracted pharmacies. Refer to the *Schedule of Benefits* to determine *your* required *copayment* and/or *coinsurance*.

If determined to be *medically necessary*, quantity limitations are two commercial packages of vials, pens, syringes or one commercial package of cartridges per *copayment* and/or *coinsurance* payment.

CONTRACEPTIVES AND PREVENTIVE PHARMACY
Contraceptive drugs and devices are covered and require a prescription from *your network provider*.

Generic class Food and Drug Administration approved contraceptive methods for all women with reproductive capacity are covered when dispensed by a *network pharmacy*. FDA approved *over-the-counter* contraceptive methods for women are covered when prescribed by a *network provider*. No *deductible*, *copayment* and/ or *coinsurance* shall apply for each prescription or refill of a *generic drug* when dispensed by a *network pharmacy*. If a *generic drug* is not available, no *deductible*, *copayment* and/ or *coinsurance* shall apply for each prescription or refill of a *brand name drug*. *Deductible*, *copayment* and/ or *coinsurance* will apply to *brand name drugs* that have *generic* equivalents.

No *deductible*, *copayment* and/or *coinsurance* shall apply for each prescription or refill of a *generic drug* when dispensed by a *network pharmacy*. If a *generic drug* is not available, no *deductible*, *copayment* and/or *coinsurance* shall apply for each prescription or refill of a *brand name drug*. *Deductible*, *copayment* and/or *coinsurance* will apply to *brand name drugs* that have *generic* equivalents, unless the prescriber indicates the *brand name drug* is *medically necessary*.

SMOKING CESSATION MEDICATIONS
Smoking cessation medications, including Over the Counter medications that have been approved by *our* Pharmacy and Therapeutic Committee, are a covered benefit.

For information regarding the smoking cessation program available from Ambetter, contact Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

MEDICAL FOODS
Medical Foods prescribed or ordered under the supervision of a *network physician* or registered nurse practitioner will be covered if *medically necessary* for the therapeutic treatment of an Inherited Metabolic Disorder or to prevent mental or physical impairment arising from an Eosinophilic Gastrointestinal Disorder as defined in this *outpatient prescription drug* Benefit.

Medical foods *coverage* must:

- Be part of the newborn screening program;
- Involve amino acid, carbohydrate or fat metabolism;
- Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues.

Medical foods *coverage* for Eosinophilic Gastrointestinal Disorder (EGD) m*ust*:

- Be diagnosed with EGD by a disease *specialist*.

RESIDENTIAL ENTERAL TUBE FEEDING

Medically necessary Enteral Nutrition is a *covered expense* when all of the following apply:

- Prescribed by a *network physician*;
- For use in the home through enteral feeding tubes;
- Feedings exceed 750 kilocalories a day in order to maintain weight and strength commensurate with the *member's* overall health status.

If the requirements above for enteral nutrition are met, supplies, including but not limited to bags, tubing, syringes, irrigation solution, dressings, and tape are also a *covered expense*.

Please note Residential Enteral Tube Feeding is covered under the Medical Supplies benefit for Individuals with an Ambetter *outpatient prescription drug* Benefit. Refer to the Medical Supplies benefit for a description of *covered services* and limitations that apply.

EXCLUSIONS AND LIMITATIONS

Prescription Medications

Outpatient prescription medications except as specifically described in the benefit description titled *Diabetic Supplies, Equipment and Devices*, or as otherwise listed as a Covered Service herein or in the *Schedule of Benefits*. Non- *covered services* include:

- *Drugs* obtained from a *non-network pharmacy.*
- Take home *prescription drugs* and medications from a *hospital* or other *inpatient* or *outpatient facility*;
- Supplies, medications and equipment labeled "Caution - Limited by Federal Law to Investigational Use";
- *Drugs* or dosage amounts determined by *us* to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether the drugs or dosage amounts have been approved by any governmental regulatory body for that use.
- Supplies, medications and equipment deemed *experimental, unproved or investigational* by *us*, except for covered Preventive Medications (as determined to be preventive as recommended by the United States Preventive Services Task Force (USPSTF) A and B recommendations (medications listed at www.uspreventiveservicestaskforce.org/usptsf/uspsabrecs.htm)
- Any non-prescription or *over-the-counter* drugs, devices and supplies that can be purchased without a prescription or *physician* order is not covered, even if the *physician* writes a prescription or order for such *drug*, unless it is an FDA approved *over-the-counter* contraceptive method for women, when prescribed by a *network provider*. Additionally, any *prescription drug* for which there is a therapeutic interchangeable non-prescription or *over-the-counter* drug or combination of non-prescription or *over-the-counter* drugs is not covered, except as prescribed for treatment of diabetes and for smoking cessation;
- Supplies, medications and equipment for other than FDA approved indications;

- "Off label" use of medications, except for certain FDA approved drugs used:
  - for the treatment of cancer in accordance with state law provided that the drug is not contra-indicated by the FDA for the off-label use prescribed; or
  - for the treatment of other specific medical conditions provided the drug is not contraindicated by the FDA for the off-label use prescribed and such use has been proven safe, effective and accepted for the treatment of the condition as evidenced by supporting documentation in any one of the following: (a) the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Drug Information; or (b) results of controlled clinical studies published in at least two peer-reviewed national professional medical journals;
- Any *drug* consumed at the place where it is dispensed or that is dispensed or administered by the *physician*;
- Supplies, medications and equipment that are not *medically necessary*; as determined by us;
- Replacement prescriptions for any reason;
- Medications for infertility;
- Medications purchased before a *member's effective date* of *coverage* or after the *member's* termination date of *coverage*;
- Medications used for *cosmetic* purposes as determined by *us*;
- Vitamins, except those included on Ambetter's Formulary;
- Weight reduction programs and related supplies to treat obesity, except as covered under Preventive Care;
- Documented growth hormone deficiency due to a hypothalamic or pituitary condition;
- Enteral Nutrition when adequate nutrition is possible by dietary adjustment, counseling and/or oral supplements; and
- Drugs that require a prescription by their manufacturer, but are otherwise regulated by the FDA as a medical food product and not listed for a covered indication listed in this document.

Prescription Drug Exception Process

Standard exception request

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

Expedited exception request

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

External exception request review

If *we* deny a request for a standard exception or for an expedited exception, the *member*, the *member's* designee or the *member's* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. *We* will make our

determination on the external exception request and notify the *member*, the *member's* designee or the *member's* prescribing *physician* of *our coverage* determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.

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

PROSTHETIC DEVICES

Internal *prosthetic*/medical appliances are *prosthetics* and appliances that are permanent or temporary internal aids and supports for missing or nonfunctional body parts, including testicular implants following medically appropriate surgical removal of the testicles. Medically appropriate repair, *maintenance* or replacement of a covered appliance is covered.

Covered Services include:

- *Prosthetic devices* including external prosthesis when they are determined to be *medically necessary* and result from an *illness*, *injury*, or surgery causing anatomical functional impairment, or from a *congenital defect*. *Coverage* includes the fitting and purchase of a standard model. Replacement of devices is covered only if determined *medically necessary* or results from a change in the *member's* physical condition or as result of wear and tear.
- Artificial limbs including the initial purchase, and subsequent purchases due to physical growth, for a covered *member* that meets all other screening criteria. *Covered Services* must be obtained from a *network provider* in order to be covered. *Coverage* is limited to limbs that are necessary because of an *illness*, *injury* or surgery causing anatomical functional impairment, or from a *congenital defect.*
- Wigs and hair pieces, limited to one per *calendar year*. *Members* must provide a valid prescription verifying diagnosis of alopecia as a result of chemotherapy, radiation therapy, or second or third degree burns with a submitted *claim* for *coverage*.
- The first pair of contacts or corrective lenses following cataract surgery, treatment of aphakia, treatment of keratoconus or corneal transplantation, including a frame allowance up to $75 subject to the limitations stated herein.
- Surgically implanted internal *prostheses* and functional devices that *we* determine to be *medically necessary* to correct a significant functional disorder (e.g. heart pacemakers and hip joints).
- Mastectomy bras are limited as shown in the Schedule of Benefits.
- Repair and/or replacement of equipment or parts due to normal wear and tear is covered only when *medically necessary*.
- *Prosthetic* terminal *devices*, including *prosthetics* that substitute for the function of a hand (such as a hook or hand).

Covered Services do not include:

- Repairs and/or replacement of parts or devices worn out due to misuse or abuse.
- Model upgrades.
- Custom breast prosthesis.
- Any costs or expenses for or related to penile implants.
- Any biomechanical devices. Biomechanical devices are any external *prosthetics* operated through

or in conjunction with nerve conduction or other electrical impulses.

RECONSTRUCTIVE SURGICAL SERVICES

Covered Services include:

- Surgeries for the correction of disease or *injury* which cause anatomical functional impairment. *Coverage* of surgical procedures will be based upon the reasonable expectation that the condition or disease will be corrected. The determination process will include *our* clinical and medical criteria.
- Reconstructive surgery incidental to *congenital defects* of a covered *dependent*. *Coverage* is limited to the *medically necessary* care and treatment of medically diagnosed *congenital defects* and birth abnormalities of a newborn, adopted child or child placed for adoption. Surgery will be covered past the *newborn period* if *medically necessary* and medical criteria are met.
- Surgical services for breast reconstruction and for post-operative *prostheses* incidental to a *medically necessary* mastectomy. *Coverage* includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, *prostheses* and physical complications for all stages of mastectomy, including lymphedemas and external postoperative *prostheses* subject to all of the terms and conditions of the *policy*.

Covered Services do not include:

- Reconstructive surgery to correct an abnormal structure resulting from trauma or disease when there is no restorative function, except as specifically provided herein.
- Breast reduction which is not *medically necessary*, except following a covered mastectomy as specifically provided herein.
- Rhinoplasty and associated surgery, rhytidectomy or rhytidoplasty, breast augmentation (except following a covered mastectomy as specifically stated herein), blepharoplasty without visual impairment, otoplasty, skin lesions when there is no functional impairment or suspicion of malignancy or located in an area of high friction, or keloids, procedures utilizing an implant which does not alter physiologic function, treatment or surgery for sagging or extra skin, or liposuction.

REHABILITATION SERVICES

Short term Rehabilitation Services and treatments for *acute* conditions when significant improvements can be expected in a predictable period of time are covered. A "predictable period of time" means the length of time as submitted by the *Primary Care Physician* or referring *physician* or as determined by the rehabilitation *specialist*, and will require *Prior Authorization* by *us*.

Rehabilitative Services include, but are not limited to, the following:

- Physical therapy
- Occupational therapy
- Cardiac rehabilitation
- Pulmonary rehabilitation
- Speech and language services limited to:
    1. Corrections of speech impairment, cognitive or perceptual deficits related to an Accident, *injury*, stroke or surgical procedure or Autism Spectrum Disorder.
    2. Therapies for organic swallowing disorders that are related to a medical condition, such as multiple sclerosis and muscular dystrophy.

Rehabilitation therapy for physical impairments in *members* with Autism Spectrum Disorders that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered *medically necessary* when criteria for rehabilitation therapy are met.

Please refer to the *Schedule of Benefits* for maximum allowable day limit per *calendar year*.

Except for *medically necessary* services related to behavioral health treatment for Autism Spectrum Disorders, the following limitations apply to Rehabilitative Services:

- Routine and/or non- *acute* speech therapy is not covered.
- Services and treatment must be for *acute* impairment of capacity due to *accidental injury* or other medical conditions.
- Services are provided on either an *outpatient*, *inpatient* or home basis as determined by the *Primary Care Physician*, referring *physician* or rehabilitation *specialist* and *us*.
- Rehabilitative services are limited to the maximum allowable number of days per Year, as specified in the *Schedule of Benefits***,** for all services and conditions combined regardless of the number of *injuries* or *illnesses* in one *calendar year*.
- Services provided on the same day, regardless of place of service (*inpatient* rehabilitation, *home health*, or *outpatient facility*, or any combination thereof), will count as one day towards the maximum allowable number of days per Year, as specified in the *Schedule of Benefits*.
- Rehabilitative services provided during an *inpatient hospitals* stay for which rehabilitation is not the primary reason for the *hospital* stay, will not apply to the maximum allowable number of days per Year, as specified in the Schedule of Benefits.
- Rehabilitative services related to 1) Developmental delay; 2) Maintaining physical condition; 3) *maintenance* therapy for a Chronic Condition are not *covered services.*
- Continued and repetitive rehabilitative treatment without a clearly defined endpoint is considered *maintenance* and is not covered.
- Functional capacity or work capacity evaluations are not covered.

SECOND OPINION

This plan covers second opinion by a *physician*. A second opinion is an additional evaluation of a *member's* condition by a *physician* to provide his or her view about the condition and how it should be treated. To request a *referral* to a *specialist* for a second opinion, contact *your Primary Care Physician*. All second opinions must be provided by a *physician* who has training and expertise in the *illness*, disease or condition associated with the request.

SKILLED NURSING SERVICES

Skilled Nursing Facility Services are covered when determined to be *medically necessary*. *Covered Services* include:

- Admission to a *Skilled Nursing Facility* when appropriate and *medically necessary*.
- Medical care and treatment, including room and board in semi-private accommodations at a *Skilled Nursing Facility* which is a *network provider* for non- *custodial care*.
- *Covered Services* shall be of a temporary nature and must be supported by a treatment plan.
- *Covered Services* must be approved in advance through *your Primary Care Physician* and *us* with expectations of rehabilitation and increased ability to function within a reasonable and generally predictable period of time.

Covered Services do not include:

- Custodial or domiciliary care.
- Long-term care admissions

SPINAL MANIPULATIONS

Covered Services for spinal manipulations are covered when determined to be *medically necessary*.

TELEMEDICINE SERVICES

Telemedicine refers to services delivered through a two-way communication that allows a *health professional* to interact with a *member*, through the use of audio, video, or other electronic media for the purpose of diagnosis, consultation or treatment.

We will provide health care services through telemedicine under, the following conditions:

- We would otherwise provide *coverage* for the service when provided in person by the *health professional*; and
- The *member* is accessing care through an In-Network Provider as defined by their Health Plan.

The following definition applies to the terms mentioned in this provision only. Health Care Services includes, but is not limited to, services provided for the following conditions or in the following settings, including:

- Trauma
- Burn
- Cardiology
- Infectious Diseases
- Mental Health Disorders
- Neurologic Diseases including Strokes
- Dermatology
- Pulmonary Services

Services not covered include but are not limited to:

Services through telemedicine if such services are not otherwise covered when provided in-person. Additionally, the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail without an interaction between the *member* and health care *provider* for the purpose of diagnosis, consultation or treatment is also not covered.

TEMPOROMANDIBULAR SERVICES (TMJ)

Covered Services include *medically necessary* services and treatment for temporomandibular joint syndrome (TMJ) including diagnosis and treatment of TMJ that is recognized by the medical or dental profession as effective and appropriate treatment, including intra-oral splints that stabilize the jaw joint.

Covered Services include services that arise from the following:

- *Accidental injury*
- Physical trauma to the mandible or lower jaw
- Tumor
- *Congenital defects* or developmental defect

- Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthognathic in nature or change the occlusion of the teeth (external or intra-oral) are covered if approved as *medically necessary*

Surgery and Related Services (Often Referred to as "Orthognathic Surgery" or "Maxillary and Mandibular Osteotomy")

For the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw or associated bone joints, except when such procedures are *medically necessary*. However, spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental implants and other dental appliances are not covered for Covered Persons age 19 and over under any circumstances.

The *copayment* or *coinsurance* for TMJ services in connection with *acute* dislocation of the mandible will vary by place of service pursuant to the *inpatient* and *outpatient services* benefits, respectively. Refer to the Schedule of Benefits to determine the applicable *copayment* and/or *coinsurance*.

TRANSPLANT SERVICES - ORGAN & TISSUE
Medically necessary required organ and tissue transplants are *covered services* as listed below when ordered or arranged by a *network physician* and *our* Medical Director. All transplants are *authorized* based on specific medical and eligibility criteria in order to be covered. In every case, *our* Medical Director must determine the *medical necessity* of the transplant. Any transplant which is specifically excluded under the *Policy* will not be covered. *Covered expenses* are payable under the *Policy* when medical eligibility criteria adopted by *us* are met and when services are provided in an accredited *facility*, where applicable, and licensed to deliver the appropriate level of care as dictated by *medical necessity*.

*We us*e established medical criteria when determining benefits and *coverage* for internal organ and tissue transplants. *We* will provide *coverage* for all Medical and *hospital services* in connection with *medically necessary* transplant surgery based on current criteria.

Organ and tissue transplants such as the following are covered:

- Heart
- Simultaneous Heart / Lung
- Kidney
- Liver for children with biliary atresia
- Bone marrow transplants for aplastic anemia and leukemia, and allogenic bone marrow transplants for severe combined immunodeficiency syndrome and Wiskott-Alsdrich syndrome
- Simultaneous Kidney / Pancreas
- Pancreas
- Liver
- Lung
- Cornea
- Autologous and Allogenic Bone Marrow Stem Cell
- Small bowel/liver
- Kidney/liver

FDA approved ventricular assist devices (VADs) are covered as a bridge to transplant when used according to FDA labeling instructions. VADs are not covered when used as artificial hearts.

Donor Searches and Coverage
Donor searches are not covered.

Coverage includes *medically necessary* services, supplies and medications provided to a donor of organs and/or tissues, whether or not the donor is a *member* of Ambetter. Such *coverage* is only available for the purpose of obtaining organs or other tissue for transplants where the recipient is an Ambetter *member*.

Covered Services for transplants do not include:

- Services, supplies and medications provided to a donor of organs and/or tissue, for transplants where the recipient is not an Ambetter *member*.
- Transplants that are considered *experimental, unproved or investigational*.
- Non-human or artificial organs, and the related implantation services.
- Donor searches
- Collection and/or storage of blood products to include stem cells for any unscheduled medical procedure, or non-covered medical procedures.
- VADs when used as an artificial heart.

Transplant Travel Services
Qualified Travel Expenditures incurred by the *member* in connection with an *authorized* organ/tissue transplant are covered subject to the following conditions and limitations. *Qualified Travel Expenditures* are limited to $10,000 per transplant. Transplant travel benefits are not available for cornea transplants.

Benefits for transportation, lodging and food are available only for the recipient of a pre-approved organ/tissue transplant from a transplant *facility*. The term recipient is defined to include a *member* receiving *authorized* transplant related services during any of the following:

1. Evaluation;
2. Candidacy,
3. Transplant event, or
4. Post-transplant care.

All *claims* filed for travel expenses must include detailed receipts, except for mileage. Transportation mileage will be calculated by *us* based on the home address of the *member* and the transplant site.

Qualified Travel Expenditures for the *member* receiving the transplant will include charges for:

1. Transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant *facility*);
    a. Transportation to and from the transplant site in a personal vehicle will be reimbursed at 37.5 cents per mile when the transplant site is more than 60 miles one way from the *member's* home.
2. Lodging while at, or traveling to and from the transplant site;
3. Food while at, or traveling to and from the transplant site.

In addition to the *member* being covered for the charges associated with the items above, such charges will also be considered covered *Qualified Travel Expenditures* for one companion to accompany the

member. The term companion includes *your* spouse, a *member* of *your* family, *your* legal guardian, or any person not related to *you*, but actively involved as *your* caregiver.

URGENT CARE SERVICES
We encourage *members* to contact their *Primary Care Physician* before seeking *urgent care* services.

Urgent Care is defined as those services, which are provided for the relief of *acute* pain, initial treatment of *acute* infection, or a medical condition that requires medical attention, but a brief time lapse before care is obtained does not endanger life or permanent health. Examples of *urgent care* Services would include minor sprains, fractures, pain, and heat exhaustion. An individual patient's urgent condition may become *emergent* upon evaluation by a *network provider*.

Covered Services for *urgent care*:

- Include treatment for unforeseen medical conditions (initial visit only).
- Are determined by the Plan in accordance with generally accepted medical standards to have been necessary to treat a condition requiring prompt medical attention.
- Require the *member* to provide full details, including medical records of *urgent care* services rendered by a *non-network provider*, if requested by this Health Plan. Costs associated with *urgent care* services will be reimbursed only after *we* receive and review the *urgent care* medical records and determines that such services were *medically necessary*. Services which have been *authorized* will not be retrospectively denied during the review of expenses incurred.

Covered Services do not include:

- Continuing, routine or follow-up care in an *Urgent Care Facility*, unless *authorized* by *your Primary Care Physician*.

Services performed at an *Urgent Care* Facility (including but not limited to: x-rays and lab testing) may be subjected to additional *cost sharing* above the *urgent care cost sharing*.

***Routine Care* provided by an *Urgent Care Provider* is not covered unless *authorized* by *your Primary Care Physician*.** The *member* will be financially responsible for any *urgent care provider* expenses for non- *urgent care*. *Routine care* includes, but is not limited to, conditions such as colds, flu, sore throats, superficial injuries, minor infections, follow-up care and preventive care.

PEDIATRIC VISION SERVICES
Pediatric Vision Services when *medically necessary* are covered until the end of the month in which the member turns 19 years of age. To receive maximum benefits, *you* must utilize *network providers*. A list of *network providers* is available at www.ambetterhealthnet.com or by calling Member Service at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

Covered Services are limited to:

- Routine eye exams (separate office visit) limit: 1 per *calendar year* (exam and hardware);
- Subnormal or Low Vision Aids: 4 comprehensive low vision evaluations every 5 years; low vision aids, including high-power spectacles, magnifiers or telescopes (limited to 1 aid per year)One pair of Prescription Lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of contacts every *calendar year*, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
- One pair of Frames per calendar year; and

- Contact Lenses limit: 1 supply per year in lieu of eyeglasses *coverage* for *medically necessary* Glasses.

MEDICAL VISION SERVICES
Covered services include:
- Vision screenings to diagnose and treat a suspected disease or *injury* of the eye.
- Vision screenings to determine the presence of refractive error.
- *Members* who have been diagnosed with diabetes may self-refer once each Year to an eye care *specialist* within their *network*, or an Ambetter contracted eye care *specialist* if none is available within the Ambetter *network*, for the purpose of receiving an eye exam for the detection of eye disease. Continued, or follow-up care from the eye care *specialist* will require a *referral* through *your Primary Care Physician*.

Vision Services under the medical portion of *your health plan* do not include:
- *Referrals* to a *specialist* for evaluation and diagnosis of refractive error, including presbyopia, for *members* over the age of 19 years.
- Eye examinations required by an employer or as a condition of employment.
- Radial keratotomy, LASIK and other refractive eye surgery.
- Services or materials provided as a result of any workers' compensation law, or required by any governmental agency. Orthoptics, vision training or subnormal vision aids.

X-RAY AND LABORATORY SERVICES
Covered Services include:
- Diagnostic x-rays
- Electrocardiograms
- Laboratory tests
- Portable x-rays
- X-ray therapy
- Fluoroscopy
- Therapeutic radiology services
- Mammography screenings

Copayments and *coinsurance* may be different depending on whether the services are received at a *physician's* office, or a *hospital*, *Outpatient* Surgery Facility or *Ambulatory Surgical Facility*.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

In addition to the Limitations and Exclusions described in the section titled *Description of Benefits* the following services are not covered or are limited in benefit application unless expressly stated herein:

Abortions
Elective abortions are not covered under this Health Plan. Abortions which are determined to be *medically necessary* to save the life of the member, or due to rape, incest, life-endangerment, or necessary to avert substantial and irreversible impairment of a major bodily function of the member having the abortion are covered.

Alternative Therapies
Acupuncture, acupressure, hypnotherapy, biofeedback (for reasons other than pain management, and for pain management related to Mental Health and Substance Abuse) behavior training, educational, recreational, art, dance, sex, sleep or music therapy, and other forms of holistic treatment or alternative therapies, unless otherwise specifically stated as a covered benefit herein.

Applied Behavioral Health Therapy (ABA)
ABA is only covered for the treatment of Autism Spectrum Disorder. The following services are not covered:

- Sensory Integration,
- LOVAAS Therapy and
- Music Therapy.

Bariatric Surgery
We provide*s* benefits for *medically necessary* and not *experimental, unproved or investigational*. These *covered services* must be *authorized* by *us* in accordance with *our* evidence based criteria for this intervention contained in *our* National Medical Policy on Bariatric Surgery which can be found at www.ambetterhealthnet.com under the medical policies link. Benefits are not payable for expenses excluded in the EOC or for the following:

- Jejunoileal bypass (jejuno-colic bypass)
- Loop Gastric Bypass (i.e., "Mini-Gastric Bypass")
- Open sleeve gastrectomy
- Gastric balloon
- Gastric wrapping
- Gastric Imbrication
- Gastric pacing
- Fobi pouch

Benefits or Services (Non-Covered)
Services, supplies, treatments or accommodations which:

- Are not *medically necessary* except as specifically described herein;
- Are not specifically listed as a Covered Service herein, whether or not such services are *medically necessary*;
- Are incident or related to a non-Covered Service;
- Are not considered generally accepted health care practices;
- Are considered *cosmetic* as determined by *us*, unless specifically listed as a *coverage* herein;

- Are provided prior to the *effective date* of *coverage* hereunder, or after the termination date of *coverage* hereunder;
- Are provided under Medicare or any other government program except *Medicaid*;
- The person is not required to pay, or for which no charge is made.

Blood Products
Collection and/or storage of blood products to include stem cells for any unscheduled medical procedure, or non-covered medical procedures. Salvage and storage of umbilical cord and/or after birth are not covered.

Braces
- *Over-the-counter* braces;
- Prophylactic braces;
- Braces used primarily for sports activities.

Breast Implants, Prostheses
Breast implants, including replacement, except when *medically necessary*, and related to a *medically necessary* mastectomy. Removal of breast implants, except when *medically necessary*.

Chiropractic Care
- Any services provided by a *non- network chiropractor* regardless of whether the services were obtained within or outside of the Health Plan's Service Area;
- Any services, including consultations (except for the initial evaluation visit), that are not *authorized* by the designated Chiropractic *provider* as shown in the Schedule of Benefits;
- Any treatments or services, including x-rays, determined to not be related to neuromusculoskeletal disorders as defined by the designated Chiropractic *provider* as shown in the Schedule of Benefits;
- Services which are not provided in a *network chiropractor's* office;
- Services or expenses which exceed the *member's* maximum allowable benefit. Services which exceed the *member's* maximum allowable benefit will be the *member's* financial responsibility;
- Expenses incurred for any services provided before *coverage* begins or after *coverage* ends according to the terms of this *Policy*;
- Preventive care, educational programs, non-medical self-care, self-help training, or any related diagnostic testing, except that which occurs during the normal course of covered chiropractic treatment;
- Prescription medications. Vitamins, nutritional supplements or related products, even if they are prescribed or recommended by a *network chiropractor*;
- Services provided on an *inpatient* basis;
- Rental or purchase of Durable Medical Equipment, air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices, appliances or equipment as ordered by *network chiropractor* even if their use or installation is for the purpose of providing therapy or easy access;
- Expenses resulting from a missed appointment which the *member* failed to cancel;
- Treatment primarily for purposes of obesity or weight control;
- Vocational rehabilitation and long-term rehabilitation;
- Hypnotherapy, acupuncture, behavior training, sleep therapy, massage or biofeedback;

- Radiological procedures performed on equipment not certified, registered or licensed by the State of Arizona, or the appropriate licensing agency, and/or radiological procedures that, when reviewed by the designated Chiropractic *provider* as shown in the Schedule of Benefits, are determined to be of such poor quality that they cannot safely be utilized in diagnosis or treatment;
- Services, lab tests, x-rays and other treatments not documented as clinically necessary as appropriate or classified as *experimental, unproved or investigational* and/or as being in the research stage;
- Services and/or treatments that are not documented as *medically necessary* services;
- All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids;
- Adjunctive therapy not associated with spinal, muscle or joint manipulation;
- Manipulation under anesthesia.

Circumcision
Non- *medically necessary* circumcisions after the *newborn period*, including cases of premature birth.

Communication and Accessibility Services
Provider expenses for interpretation, translation, accessibility or special accommodations.

Complications of Non-Covered Expenses
Complications of an ineligible or excluded condition, procedure or service (non- *covered expenses*), including services received without *authorization*.

Cosmetic Surgery or Reconstructive Surgery
Cosmetic or Reconstructive surgery, which in the opinion of *us* is, performed to alter an abnormal or normal structure solely to render it more esthetically pleasing where no significant anatomical functional impairment exists. The following are examples of non- *covered services*:

- Rhinoplasty and associated surgery
- Rhytidectomy or rhytidoplasty
- Breast augmentation/implantation
- Blepharoplasty without visual impairment
- Breast reduction which is not *medically necessary*, as determined by *us*
- Otoplasty
- Skin lesions without functional impairment, suspicion of malignancy or located in area of high friction
- Keloids
- Procedures utilizing an implant which does not alter physiologic function
- Treatment or surgery for sagging or extra skin
- Liposuction
- Mon- *medically necessary* removal or replacement of breast implants, as determined by *us*

Cosmetic or Reconstructive surgery performed, in our opinion, to correct injuries that are the result of *accidental injury* is a Covered Service. In addition, this exclusion does not apply to breast reconstruction incidental to a covered mastectomy for either the breast on which the mastectomy has been performed or for surgery and reconstruction of the other breast to produce a symmetrical appearance. Reconstructive surgery incidental to birth abnormalities of a Covered *dependent* is limited to the *medically necessary* care

and treatment of medically diagnosed *congenital defect* and birth abnormalities of a newborn, adopted child or child placed for adoption. Surgery will be covered past the *newborn period* if *medically necessary* and medical criteria are met.

Counseling Services
Unless otherwise specifically stated as a covered benefit herein.

- Counseling for conditions that DSM identifies as relational problems (e.g. couples counseling, family counseling for relation problems)
- Counseling for Conditions that the DSM identifies as additional conditions that may be a focus of clinical attention (e.g. educational, social, occupational, religious, or other maladjustments)
- Sensitivity or stress-management training and self-help training

Court or Police Ordered Services
Examinations, reports or appearances in connection with legal proceedings, including child custody, competency issues, parole and/or probation and other court ordered related issues. Services, supplies or accommodations pursuant to a court or police order, whether or not *injury* or sickness is involved, unless otherwise noted within the policy.

Custodial Care
Any service, supply, care or treatment that *we* determine to be incurred for rest, domiciliary, convalescent or *custodial care*. Examples of non- *covered services* include:

- Any assistance with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medications;
- Any care that can be performed safely and effectively by a person who does not require a license or certification or the presence of a supervisory nurse;
- Non-covered *custodial care* Services no matter who provides, prescribes, recommends or performs those services;
- Services of a person who resides in the *member's* home, or a person who qualifies as a *family member*;
- The fact that certain *covered services* are provided while the *member* is receiving *custodial care* does not require *us* to cover *custodial care*.

Dental Services
The *medical* portion of *your health plan* covers only those dental services specifically stated in the section titled *Description of Benefits*. All other dental services are excluded.

Devices
Bionic and hydraulic devices, except when otherwise specifically described herein.

Diabetic Supplies, Equipment and Devices
Diabetic supplies are covered when *medically necessary*. The following are specific requirements for *coverage*:

- Diabetic supplies must have a written prescription from a *provider*, when *medically necessary*.
- Refills are covered only when *authorized* by a *provider*, when *medically necessary*.
- *Covered Services* must be obtained from a *provider* unless otherwise *authorized* by *us*.
- Plan approved standard blood glucose monitors are covered for both insulin-dependent and non-insulin-dependent *members* when necessary for medical management as determined by *us* in con-

sultation with *your physician*. Blood glucose monitors require a prescription from a *physician* and must be obtained at a Pharmacy.
- Plan approved blood glucose monitors for the legally blind are covered when *medically necessary* and the *member* has been diagnosed with diabetes. Blood glucose monitors require a written prescription from a *physician* and must be obtained at a Pharmacy.

Dietary Food or Nutritional Supplements
Non- *covered services* include the following:
- Dietary food, nutritional supplements, special formulas, and special diets provided on an *outpatient*, ambulatory or home setting;
- Food supplements and formulas, including enteral nutrition formula, provided in an *outpatient*, ambulatory or home setting except as otherwise stated herein or in the *Schedule of Benefits*;
- Nutritional supplementation ordered primarily to boost protein-caloric intake or the mainstay of a daily nutritional plan in the absence of other pathology, except as otherwise stated herein or in the Schedule of Benefits. This includes those nutritional supplements given between meals to increase daily protein and caloric intake;
- Services of nutritionists and dietitians, except as incidentally provided in connection with other *covered services*.

Disability Certifications
Disability Certifications if not required by *us*.

Durable Medical Equipment
Durable Medical Equipment that fails to meet the criteria as established by *us*. Examples of Non- *covered services* include, but are not limited to the following:
- Exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses, or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, and hygienic equipment;
- Equipment for a patient in an institution that is ordinarily provided by an institution, such as wheelchairs, hospital beds and oxygen tents, unless these items have been *authorized* by *us*;
- More than one *DME* device designed to provide essentially the same function;
- Foot *orthotics*, except when attached to a permanent brace or when prescribed for the treatment of diabetes, or any of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation (refer to exclusion entitled foot *orthotics*) (This exclusion does not apply to *coverage* for special shoes and inserts for certain patients with diabetes. Please refer to *your* diabetic benefits for further specification);
- Deluxe, electric, model upgrades, *specialized or custom durable medical equipment*, *prosthetics* or *orthotics* or other non-standard equipment;
- Repair or replacement of deluxe, electric, *specialized or custom durable medical equipment*, model upgrades, and portable equipment for travel;
- Transcutaneous Electrical Nerve Stimulation (TENS) units;
- Scooters and other power operated vehicles;
- Warning devices, stethoscopes, blood pressure cuffs, or other types of apparatus used for diagnosis or monitoring,

- Model upgrades and duplicates, except as specifically listed as being covered herein;
- Repair, replacement or routine *maintenance* of equipment or parts due to misuse or abuse;
- Over-the counter braces and other *DME* devices, except as specifically listed as being covered herein;
- Prophylactic braces and other *DME* devices, except as specifically listed as being covered herein;
- Braces used primarily for sports activities;
- ThAIRapy® vests, except when *our* medical criteria is met;
- Communication devices (speech generating devices) and/or training to *us*e such devices; and
- Pulse oximeters.

Emergency Services
Use of *emergency facilities* for non-*emergency* purposes. *Routine Care*, follow-up care or continuing care provided in an Emergency Facility, unless such services were *authorized* by the *Primary Care Physician* or *us*.

Exercise Programs
Exercise programs, yoga, hiking, rock climbing and any other types of sports activity, equipment, clothing or devices.

Ex-Member (Services for)
Benefits and services provided to an ex- *member* after termination of the ex- *member.*

Experimental, Investigational Procedures, Devices, Equipment and Medications
Experimental, unproved or investigational medical, surgical or other *experimental* health care procedures, services, supplies, medications, devices, equipment or substances. *Experimental, unproved or investigational* procedures, services or supplies are those which, in *our* judgment:
- Are in a testing stage or in field trials on animals or humans;
- Do not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed;
- Are not in accordance with generally accepted standards of medical practice;
- Have not yet been shown to be consistently effective for the diagnosis or treatment of the *member's* condition;
- Are medications or substances being used for other than FDA approved indications; and/or
- Are medications labeled "Caution, Limited by Federal Law to Investigational Use."

This exclusion does not apply to *coverage* for routine patient costs provided to *members* participating in approved Clinical Trials as required by state and federal law and defined in this *Policy*.

Family Member (Services Provided by) and Member Self-Treatment
Professional services, supplies or *provider referrals* received from or rendered by a non-Ambetter contracted immediate *family member* (spouse, domestic partner, child, parent, grandparent or sibling related by blood, marriage or adoption) or prescribed or ordered by a non-Ambetter contracted immediate *family member* of the *member*; *Member* self-treatment including, but not limited to self-prescribed medications and medical self-ordered services.

Foot Orthotics
See exclusion titled *orthotics*.

Fraudulent Services
Services or supplies that are obtained by a *member* or non- *member* by, through or otherwise due to fraud.

Gastric Stapling/Gastroplasty
Open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, and open adjustable gastric banding.

Genetic Testing, Amniocentesis
Services or supplies in connection with genetic testing, except those which are *medically necessary* or included in the preventive services section, as determined by *us*. Genetic testing, amniocentesis, ultrasound, or any other procedure required solely for the purpose of determining the gender of a fetus.

Governmental Hospital Services
Services provided by any governmental unit except as required by federal law for treatment of veterans in Veterans Administration or armed forces Facilities for non-service related medical conditions. Care for conditions that federal, state, or local law requires treatment in a public *facility.*

Habilitative Services
Habilitative services when medical documentation does not support the *medical necessity* because of the *member's* inability to progress toward the treatment plan goals or when a *member* has already met the treatment plan goals.

Speech therapy is not covered for occupational or recreational voice strain that could be needed by professional or amateur voice users, including, but not limited to, public speakers, singers, cheerleaders. Examples of health care services that are not habilitative include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, *custodial care*, or education services of any kind, including, but not limited to, vocational training.

Hair Analysis, Treatment and Replacement
Testing using a patient's hair except to detect lead or arsenic poisoning; hair growth creams and medications; implants; scalp reductions.

Heavy Metal Screening and Mineral Studies
Heavy metal screenings and mineral studies. Screening for lead poisoning is covered when directed through the *Primary Care Physician*.

Home Maternity Services
Services or supplies for maternity deliveries at home.

Household and Automobile Equipment and Fixtures
Purchase or rental of household equipment or fixtures having customary purposes that are not medical. Examples of Non- *covered services* include: exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, hygienic equipment or other household fixtures.

Immunizations
Immunizations that are not *medically necessary* or medically indicated.

Impotence (Treatment of)
All services, procedures, devices associated with impotence or erectile dysfunction regardless of associated medical, emotional or psychological conditions, causes or origins unless otherwise specifically stated herein.

Ineligible Status
Services or supplies provided before the *effective date* of *coverage* not cover. Services or supplies provided after midnight on the *effective date* of cancellation of *coverage* are not covered, except as specified in the "Extension of Benefits."

A service is considered provided on the day it is performed. A supply is considered provided on the day it is dispensed.

Infertility Services
Services associated with infertility are limited to diagnostic service rendered for infertility evaluation. The following services and treatments are not covered:

- Artificial insemination services
- Reversal of voluntary sterilization procedures
- In vitro fertilization
- Embryo or ovum transfer
- Zygote transfers
- Gamete transfers
- GIFT procedure
- Cost of donor sperm or sperm banking
- Foams and condoms
- Medications used to treat infertility
- Services, procedures, devices and medications associated with impotence and/or erectile dysfunction unless otherwise specifically stated herein or in the *Schedule of Benefits*

Institutional Requirements
Expenses for services provided solely to satisfy institutional requirements.

Intoxicated or Impaired
Services or supplies for any *illness*, *injury* or condition caused in whole or in part by or related to the *member's* use of a motor vehicle when tests show the *member* had a blood alcohol level in excess of that permitted to legally operate a motor vehicle under the laws of the state in which the *accident* occurred, except in cases in which *we* determine the *illness*, *injury*, or condition was a result of a substance abuse disorder.

Late Fees, Collection Expenses, Court Costs, Attorney Fees
Any late fees or collection expenses that a *member* incurs incidental to the payment of services received from *providers*, except as may be required by state or federal law. Court costs and attorney fees. Costs due to failure of the *member* to disclose insurance information at the time of treatment.

License (Not Within the Scope of)
Services beyond the scope of a *provider's* license

Lost Wages and Compensation for Time
Lost wages for any reason. Compensation for time spent seeking services or *coverage* for services.

Medical Supplies
Consumable or disposable medical supplies, except as specifically provided herein. Examples of non-*covered services* include bandages, gauze, alcohol swabs and dressings, foot coverings, leotards, elastic knee and elbow Supports not provided in the *Primary Care Physician's* office, except as required by state or Federal law. Medical supplies necessary to operate a non-covered *prosthetic device* or item of *DME*.

Mental Health
Covered Services do not include the following:

- Treatment for chronic or organic conditions, including Alzheimer's, dementia or delirium. Delirium will not be excluded when reported as a symptom of treatment for a Mental Disorder or Substance Use Disorder according to the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, or the most recent edition of the International Classification of Diseases, Tenth Revision. This exclusion does not apply to the initial assessment for diagnosis of the condition;
- Ongoing treatment for mental disorders that are long-term or chronic in nature for which there is little or no reasonable expectation for improvement, unless reported as symptoms of treatment for a Mental Disorder or Substance Use Disorder according to the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, or the most recent edition of the International Classification of Diseases, Tenth Revision.. These disorders include mental retardation, and organic brain disease. This exclusion does not apply to the initial assessment for diagnosis of the condition;
- Mental Health treatment of erectile dysfunction and sexual dysfunction;
- Counseling, testing, evaluation, treatment or other services in connection with the following are not covered unless reported as symptoms of treatment for a Mental Disorder or Substance Use Disorder according to the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, or the most recent edition of the International Classification of Diseases, Tenth Revision: learning disorders and/or disabilities, non-medical ancillary services including but not limited to vocational rehabilitation or therapeutic approaches that are not well supported in evidence based studies, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy for learning disabilities, developmental delays and mental retardation. This exclusion does not apply to the initial assessment for diagnosis of the condition;
- Psychological testing or evaluation specifically for ability, aptitude, intelligence, interest or competency;
- Psychiatric evaluation, therapy, counseling or other services in connection with the following: child custody, parole and/or probation, and other court ordered related issues;
- Marriage counseling unless otherwise specifically stated as a Covered Service in the *Schedule of Benefits*;
- Expenses incurred for missed appointments or appointments not canceled 24 hours in advance;
- Wilderness programs and/or therapeutic boarding schools that are not licensed as *Residential Treatment Centers*; and
- Voluntary and court-ordered treatment for mental health and substance abuse are covered.

Missed Appointments, Telephone and Other Expenses
The following are not covered:

- Expenses made to *member* by a *provider* for not keeping or the late cancellation of appointments.
- Charges by *members* or *providers* for telephone consultations, except for Services provided through telemedicine if such services are otherwise covered when provided in person, and clerical services for completion of special reports or forms of any type, including but not limited to Disability certifications are not covered.
- Charges by *members* or *providers* for copies of medical records supplied by a health care *provider* to *member*.

Telemedicine services are covered as shown under the "Description of Benefits" section in this EOC.

Non-Licensed Providers
Treatment or services rendered by non-licensed health care *providers* and treatment or services outside the scope of a license of a licensed health care *provider* or services for which the *provider* of services is not required to be licensed. This includes treatment or services from a non-licensed *provider* under the supervision of a licensed *physician*, except for services related to behavioral health treatment for Pervasive Developmental Disorder or Autism.

Non-Medically Necessary Services
Services, supplies, treatments or accommodations which are not *medically necessary* except as specifically described herein.

Non-Participating Pharmacy
Benefits and services from *non- network pharmacies* (any Pharmacy that has not contracted with Ambetter from Health Net to provide prescription medications to *members* covered under this *Policy*) are not covered. This can include specific stores within a chain of stores.

Non-Participating Provider (Services Rendered by)
Benefits and services from *non-network providers*, except in the case of a medical *emergency.*

Nutritionists
Services of nutritionists and dietitians, except as incidentally provided in connection with other *covered services*.

Obesity
Treatment or surgery for obesity, weight reduction or weight control, except when provided for morbid obesity or as a Preventive Care Services.

Orthotics

- Repair, *maintenance* and repairs due to misuse and/or abuse.
- *Over-the-counter* items, except as specifically listed as being covered herein.
- Prophylactic braces.
- Braces used primarily for sports activities.
- Foot *orthotics*, except when attached to a permanent brace or when prescribed for the treatment of diabetes, or any of the following complications involving the foot: Peripheral neuropathy with

evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation.

Out-of-Service Area Services
Unauthorized services received outside of Ambetter's Service Area, except for *emergency services* as defined in this *Policy*. Examples of non- *covered services* include the following:

- Services or treatments which could have been provided by a *network provider* within the Service Area;
- Services which were furnished after the *member's* condition would have permitted the *member* to return to the Service Area for continued care;
- Services connected with conditions resulting during travel which had been advised against because of health reasons such as impending surgery and/or delivery. This does not apply to *emergency services* as defined in this *Policy*; and
- Treatment in progress by a *network provider*.

Over-the-Counter Items and Medications
Over-the-counter items and medications, except as specifically listed as a covered benefit herein or in the *Schedule of Benefits*. Exceptions covered herein include covered Preventive Medications, and medications as indicated under the provisions titled Diabetic Supplies, Equipment and Devices. For purposes of this *Policy*, *over-the-counter* is defined as any item, supply or medication which can be purchased or obtained from a vendor or without a prescription.

Oxygen
Oxygen when services are outside of the Service Area and non-*Emergent* or Urgent, or when used for convenience when traveling within or outside of the Service Area.

Paternity Testing
Diagnostic testing to establish paternity of a child.

Penile Implants
Any costs or expenses for or related to penile implants.

Personal Comfort Items
Personal comfort or convenience items, including services such as guest meals and accommodations, telephone expenses, non-*Qualified Travel Expenditures*, take-home supplies, barber or beauty services, radio, television and private rooms unless the private room is *medically necessary*.

Physical and Psychiatric Exams
Physical health examinations in connection with the following:

- Obtaining or maintaining employment,
- Obtaining or maintaining school or camp attendance,
- At the request of a third party,
- Sports participation whether or not school related,
- Obtaining or maintaining insurance qualification.

Psychiatric or psychological examinations, testing and/or other services in connection with:

- Obtaining or maintaining employment,
- Obtaining or maintaining insurance relating to employment or insurance,

- Obtaining or maintaining any type of license,
- Medical research,
- Competency issues.

Physical Conditioning
Health conditioning programs and other types of physical fitness training. Exercise equipment, clothing, performance enhancing drugs, nutritional supplements and other regimes.

Prescription Medications
Refer to the *outpatient prescription drug* benefit for the restrictions and limitations that apply.

Private Duty Nursing
Private Duty Nursing and private rooms except when determined to be *medically necessary* as determined by *us*. *Private Duty Nursing* does not include non-skilled care, *custodial care*, or respite care.

Public or Private School
Charges by any public or private school or halfway house, or by their employees.

Radial Keratotomy, Lasik
Radial Keratotomy, LASIK surgery and other refractive eye surgery.

Reconstructive Surgery
Reconstructive surgery to correct an abnormal structure resulting from trauma or disease when there is no restorative function expected. This exclusion does not apply to breast reconstruction following a covered mastectomy for either the breast on which the mastectomy has been performed or for surgery and reconstruction of the other breast to produce a symmetrical appearance. Reconstructive surgery incidental to birth abnormalities of a Covered *dependent* is limited to the *medically necessary* care and treatment of medically diagnosed *congenital defects* and birth abnormalities of a newborn, adopted child or child placed for adoption. Surgery will be covered past the *newborn period* if *medically necessary* and medical criteria are met.

Rehabilitation and Habilitation Services
Rehabilitation and habilitation services, *maintenance* and/or non- *acute* therapies, or therapies where a significant and measurable improvement of condition cannot be expected in a reasonable and generally predictable period of time are not covered. Rehabilitative and habilitation services related to 1) developmental delay; 2) maintaining physical condition; 3) *maintenance* therapy for a Chronic Condition are not *covered services*. However, Rehabilitation and Habilitation therapy for physical impairments in *members* with Autism Spectrum Disorders that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered *medically necessary* when criteria for rehabilitation and habilitation therapy are met.

Residential Treatment Center
Residential treatment that is not *medically necessary* is excluded. Admissions that are not considered medically appropriate and are not covered include admissions for wilderness center training; for *custodial care*; for a situational or environmental change; or as an alternative to placement in a foster home or halfway house.

Reversal of voluntary sterilization procedures
Expenses for services to reverse voluntary sterilization.

Riots, War, Misdemeanor, Felony
Illness or *injury* sustained by a *member* caused by or arising out of riots, war (whether declared or undeclared), insurrection, rebellion, armed invasion or aggression. *Illness* or *injury* sustained by a *member* while in the act of committing a misdemeanor, or felony, or while engaging in an illegal occupation, unless the condition was an *injury* resulting from an act of domestic violence or an *injury* resulting from a medical condition, mental health condition, or substance abuse disorder.

Routine Foot Care
Routine foot care. Examples of non- *covered services* include trimming of corns, calluses and nails, and treatment of flat feet.

Sexual Dysfunction
Behavioral treatment for sexual dysfunction and sexual function disorders regardless if cause of dysfunction is due to physical or psychological reasons.

Shipping, Handling, Interest Expenses
All shipping, delivery, handling or postage expenses except as incidentally provided without a separate charge, in connection with *covered services* or supplies. Interest or finance charges except as specifically required by law.

Skin Titration Testing
Skin titration (wrinkle method), cytotoxicity testing (Bryans Test), RAST testing, MAST testing, urine auto-injection, provocative and neutralization testing for allergies.

Speech and Language Services
Speech therapy services, *maintenance* and/or non- *acute* therapies, or therapies where a significant and measurable improvement of condition cannot be expected in a reasonable and generally predictable period of time as determined by *us* in consultation with the treating *provider*. Any combination of therapies (including speech and language therapies) that exceed the maximum allowable benefits as described in the *Schedule of Benefits.* Communication devices (speech generating devices). Rehabilitative services relating to developmental delay, provided for the purpose of maintaining physical condition, or *maintenance* therapy for a Chronic Condition are not covered. However, Rehabilitation and habilitation therapy for physical impairments in *members* with autism spectrum disorders that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered *medically necessary* when criteria for rehabilitation and habilitation therapy are met.

Substance Abuse Services
Covered Services do not include:

- *Referral* for non- *medically necessary* services such as vocational programs or employment counseling.
- Expenses related to a stay at a sober living *facility*. Sober living *facilities* are *custodial care* institutions, which are not a covered benefit.

Temporomandibular Joint Disorder (Treatment of)
Covered Services under the *medical* portion of *your health plan* do not include:

- Dental prosthesis or any treatment on or to the teeth, gums, or jaws and other services customarily provided by a dentist or dental *specialist*;
- Treatment of pain or infection due to a dental cause, surgical correction of malocclusion prognathic surgery, orthodontia treatment, including *hospital* and related costs resulting from these services when determined to relate to malocclusion;
- Services related to injuries caused by or arising out of the act of chewing; and
- Treatment of obstructive sleep apnea.

Thermography
Thermography or thermograms related expenses.

Transplant Services
Covered Services for transplants do not include:

- Services, supplies and medications provided to a donor of organs and/or tissue, for transplants where the recipient is not a *member* covered under this health Plan.
- Transplants that are considered *experimental, unproved or investigational*.
- Non-human or artificial organs, and the related implantation services.
- Donor searches
- VADs when used as an artificial heart

This exclusion does not apply to *coverage* for routine patient costs provided to *members* participating in approved Clinical Trials as required by state and federal law and defined in this *Policy*.

Transportation Services
Transportation of a *member* to or from any location for treatment or consultation, except for ambulance services associated with a *medically necessary emergency* condition and travel services associated with organ transplant benefits. Travel and lodging are not covered if the *member* is a donor.

Travel Expenses
Travel and room and board, even if prescribed by a *physician* for the purpose of obtaining *covered services*. This does not apply to *Qualified Travel Expenditures*.

Urgent Care Services
Use of *Urgent Care Facilities* for non- *urgent care* purposes. *Routine Care*, follow-up or continuing care provided in an *Urgent Care Facility*.

Vision Services
Vision services are covered as specified in the Vision Services section under the Description of Benefits of this *Policy* and the *Schedule of Benefits.*

Pediatric Vision Services and supplies when *medically necessary* are covered for children up to the last day of the month he or she turns age 19, as described in the Schedule of Benefits under Pediatric Vision Services.

The following Adult Vision Services are not covered:

- Eyeglasses and contact lenses, and the vision examination for prescribing and fitting of same, except as specifically listed as a covered benefit herein.
- Eye examinations required by an employer as a condition of employment.
- Services or materials provided as a result of any workers' compensation law, or required by any government agency.
- Radial keratotomy and other refractive eye surgery.
- Orthoptics, vision training, or subnormal vision aids.

If *you* have elected additional Adult Vision Benefits, please refer to the Vision Benefit Rider for a description of services and the limitations that apply.

Vitamin B-12 Injections
Vitamin B-12 injections are not covered except for the treatment of pernicious anemia when oral vitamin B cannot be absorbed.

Vocational Programs/Employment Counseling
Vocational programs and counseling for employment, including counseling during mental or substance abuse rehabilitation.

Work-Related Injuries
Expenses in connection with a work-related *injury* or sickness for which *coverage* is provided under any state or federal Worker's Compensation, employer's liability or occupational disease law.

DEPENDENT MEMBER COVERAGE & ONGOING ELIGIBILITY

Eligibility Requirements
Coverage under this *health plan* is available to individuals who satisfy the eligibility requirements as described in this section.

Subscriber Eligibility
Eligible *members* may apply for *coverage* under this Health Plan, provided that the individual:

- Resides within Ambetter from Health Net's Service Area when applying for membership under this *Policy*;
- Is not currently enrolled in *coverage* under Medicare; or
- Satisfies either the Discretionary or Automatic Eligibility Requirements as described herein.

If the *eligible child* enrolled under this Agreement is under the age of 21 and has been enrolled by an eligible *member*, the eligible *member* signing for *coverage* on behalf of the Child agrees to be responsible for the administrative and premium requirements of the *coverage*. *Dependents* of the *eligible child* cannot be enrolled and cannot be *members* under this Agreement. No benefits shall be payable on behalf so such *dependents*.

Dependent Eligibility
Eligible *dependents* of the *member* may apply for *dependent coverage* under this *Policy*, provided that the *family member*:

1. Meets the *dependent* eligibility requirements as defined below;
2. Is not currently enrolled in *coverage* under Medicare; and
3. Satisfies either the Discretionary or Automatic Eligibility Requirements as described herein.

Eligible *dependents*, at the time of enrollment and throughout the term of *coverage* hereunder, include:

1. A *member's* lawful spouse, living within the Service Area serviced by Ambetter; or
2. A *member's* child under the age of 26. For purposes of this provision, the term child shall include a natural child, stepchild, legally adopted child, a child who has been placed for adoption with the *member*, a child under a *member's* permanent guardianship or permanent custody by court order or a child eligible for *coverage* pursuant to a Qualified Medical Child Support Order.

The term *dependent* does not include a *member's* natural child for whom legal rights have been given up through adoption or a grandchild of the *member* for whom the *member* does not have court ordered permanent guardianship or custody. Eligibility is not based on any health status related factors.

For purposes of this provision, a child must be younger than 26 years of age as of the date of adoption or placement for adoption. The term *dependent* does not include a *member's* natural child for whom legal rights have been given up through adoption, or a grandchild of the *member* r for whom the *member* does not have court ordered permanent guardianship or custody. Eligibility is not based on any health status related factors.

Attainment of the age of 26 by a *dependent* child shall not operate to terminate the *coverage* of that child while the child is and continues to be both incapable of self-sustaining employment by reason of intellectual disability or physical handicap and chiefly *dependent* on the policyholder for support and *mainte-*

nance. Proof of such incapacity and dependency shall be furnished to Ambetter from Health Net by the policyholder within thirty-one days of the child's attainment of 26 years of age and subsequently as may be required by *us* but not more frequently than annually after the two-year period following the child's attainment of the age of 26.

Enrollment Requirements
The *member* is responsible for submitting a completed and signed Enrollment Application when requesting *coverage* hereunder for himself and any eligible *dependents*. The *member* will be informed whether the Enrollment Application is approved for *coverage*. If the Enrollment Application is approved, the applicant will be notified of the amount of required Premium payment and the *effective date* of *coverage* under this Health Plan. Eligibility is not based on any health stat*us* related factors. Please note that *you* may enroll in a plan (or switch enrollment to another plan) only during certain enrollment periods as described below.

An individual or family whose application has been accepted through the *Federally Facilitated Marketplace* are covered under this plan. For more information on how to enroll, please visit www.HealthCare.gov. Please note that *you* may enroll in a plan (or switch enrollment to another plan) that is provided through the *Federally Facilitated Marketplace* only during certain enrollment periods as described below.

Open Enrollment Period: The open enrollment period is November 1st through December 15th. During this time *you* can makes changes to *your coverage*.

Special Enrollment Period: Individuals who experience certain Qualifying Events can enroll in, or change enrollment within sixty (60) days of the Qualifying Event. For certain triggering events, such as loss of minimum essential coverage, or becoming newly eligible or ineligible for federal subsidy programs, an individual has sixty (60) days before and after the event to select a plan. The *effective date* of *coverage* depends on the qualifying events.

Qualifying Events are when the following triggering events occur, including but not limited to:

- The qualified individual loses minimum essential coverage;
- Loses pregnancy-related coverage under *Medicaid*;
- Loses medically needy coverage under *Medicaid*;
- Is enrolled in any non- *calendar year* group health plan or individual health insurance coverage, even if the qualified individual or his or her *dependent* has the option to renew such coverage. The date of the loss of coverage is the last day of the plan or policy year;
- Gains a *dependent* or becomes a *dependent*, through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or any other court order;
- At the option of the Exchange, the enrollee loses a *dependent* or is no longer considered a *dependent* through divorce or legal separation as defined by state law in the state in which the divorce or legal separation occurs, or if the Enrollee, or his or her *dependent*, dies;
- Was not previously a citizen, national, or lawfully present individual and gains status;
- Enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer of the healthcare Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conduct enrollment activities ;
- The plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the *member*;

- Newly eligible or ineligible for advance payments of the premium tax credit, or change in eligibility for *cost sharing reductions*;
- A Qualified Individual in a non- *Medicaid* expansion state who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the Federal Poverty Line, who was ineligible for *Medicaid* during that same timeframe, and who has experience a change in household income that makes the Qualified Individual newly eligible for advance payments of the premium tax credit;
- Gains access to a new plan or Qualified Health Plan ("QHP") as a result of a permanent move. To qualify for a permanent move, an individual must have had minimum essential coverage for one or more days in the 60 days preceding the permanent move, unless they were living outside the United States or in a United States Territory at the time of the permanent move;
- 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
- Demonstrates to the *Health Insurance Marketplace*, in accordance with guidelines issued by the US Department of Health and Human Services ("HHS"), that the individual meets other exceptional circumstances as the *Health Insurance Marketplace* may provide.

Enrollment of Newly Eligible Dependent
Dependents of the *member* who become eligible for *coverage* after the *member's* original *effective date* must submit an Enrollment Application requesting *dependent* Coverage. The *member* will be notified of *coverage approval*, the amount of required Premium payment and the *effective date* of *coverage* for such *dependent*.

Enrollment of Newborn, Adopted Child or Child Placed for Adoption
A newborn child, legally adopted child, or child placed for adoption with the *member* is automatically covered under this *Policy* for the first 31 days following the date of birth, date of adoption or placement for adoption. To continue *coverage* after the first 31 days, the *member* must submit an Enrollment Application for such *dependent* within 60 days of the date of birth, date of adoption or placement for adoption. Failure to enroll a newborn within 60 days following the date of birth will terminate *coverage* at the end of the initial 31 day period. The continued *coverage* of the newborn after the initial 31 day period is subject to *our* receipt of Premium payment for such newborn, if applicable. The newborn will show as an active enrollee from the date of birth, adoption, or placement for adoption.

For All Members
A *member's* eligibility for *coverage* under this *contract* will continue until the earlier of:

1. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *contract* or the date that We have not received timely premium payments in accordance with the terms of this *contract*; or
2. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact (e.g., the date that a *member* accepts any direct or indirect contributions or reimbursement by or on behalf of an employer, for any portion of the premium for *coverage* under this *contract*); or
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision; or
4. The date of a *member's* death; or
5. The primary *member* residing outside the Service Area or moving permanently outside the Service Area of this plan; or

6. The date we receive a request from *you* to terminate this *contract*, or any later date stated in *your* request, or if *you* are enrolled through the Exchange, the date of termination that the Exchange provides *us* upon *your* request of cancellation to the Exchange.

Loss of Dependent Eligibility

A *dependent* whose *coverage* is terminated due to the *member's* death or due to the *member's* dissolution of marriage may convert a *dependent* membership to a new policy, provided such *dependent* meets the eligibility requirements, submits a completed and signed Enrollment Application to within 60 days of the date *dependent* is terminated, and submits the required Premium payment. The *member* will not be required to furnish evidence of insurability, but *coverage* shall be in accordance with the rules and regulations that may have in effect at the time such *dependent* applies for individual *coverage*. Such rules and regulations may include those relating to *coverage*, amount of Premium payment, and all other terms and conditions governing individual membership.

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*, *coverage* will terminate the thirty-first of December the year that the *dependent* turns 26 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. Incapable of self-s*ust*aining employment due to mental handicap or physical handicap that began before the age limit was reached; and
2. Mainly Dependent on the primary *member* for support.

Effective Dates of Coverage

Subject to the eligibility and enrollment requirements *coverage* under this *Policy*, shall become effective on the following dates:

1. For the *member* and any enrolled *dependent* whose Enrollment Application has been approved by Ambetter or the *Federally Facilitated Marketplace*, *coverage* shall commence on the date stated in Ambetter or the *Federally Facilitated Marketplace's* written approval letter;
2. For newly eligible *dependents* who become eligible after the *member's* original *effective date* of this *Policy*, *coverage* shall be effective as follows:
    a. Newborns are automatically covered for the first 31 days from the date of birth. Continued *coverage* beyond the first 31 days is subject to receipt of a signed Enrollment Application and payment of additional Premium, if required;
    b. Adopted children are automatically covered for the first 31 days following date of adoption. Continued *coverage* beyond the first 31 days is subject to receipt of a signed Enrollment Application and payment of additional Premium, if required;
    c. Children placed for adoption are automatically covered for the first 31 days from the date of placement. Continued *coverage* beyond the first 31 days is subject to receipt of a signed Enrollment Application and payment of additional Premium, if required;
    d. Other eligible *dependents*, as defined in this *Policy*, will be covered from the date specified in a letter approving *coverage* and payment of additional Premium if required.

The Exchange 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.

Change in Stat*us* – Notice Required

The *member* is responsible for notifying Ambetter or the *Federally Facilitated Marketplace* of any changes that affect his eligibility, or that of his enrolled *dependents*, for services and benefits under this *Policy*. The *member* must notify Ambetter or the *Federally Facilitated Marketplace* within 60 days of the event. This includes changes of address, addition or deletion of *dependents* resulting from death, achieving the limiting age, and changes in Dependent Disability or Dependent status. *Coverage* for ineligible *members* will terminate in accordance with the termination provisions described in this *Policy*.

PREMIUM PAYMENTS

Premium Payments
Each premium payment is to be paid on or before its due date. The initial premium payment must be paid prior to the coverage effective date, although an extension may be provided during the annual Open Enrollment.

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 Advance Premium Tax Credits are received.

We will continue to pay all appropriate *claims* for *covered services* rendered to the *member* during the first month of the *grace period*, and may pend *claims* for *covered services* rendered to the *member* in the second and third month of the *grace period*. We will notify HHS of the non-payment of premiums, the *member*, as well as *providers* of the possibility of denied *claims* when the *member* is in the second and third month of the *grace period*. We will continue to collect Advance Premium Tax Credits on behalf of the *member* from the Department of the Treasury, and will return the Advance Premium Tax Credits on behalf of the *member* for the second and third month of the *grace period* if the *member* exhausts their *grace period* as described above. A *member* is not eligible to re-enroll once terminated, unless a *member* has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

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

Return of Premium for Ineligible Enrollees
If Ambetter receives a Premium for an individual or a *member's family member* whom Ambetter determines does not satisfy the eligibility and enrollment requirements, *we* will refund those amounts applicable to the ineligible enrollee. Ineligible enrollees are not *members* of this *health plan* and shall have no right to *covered services* under this *Policy*.

Premium Payments from Third-Party Payors
Ambetter requires each policy holder to pay his or her premiums and this is communicated on *your* monthly billing statements. Ambetter payment policies were developed based on guidance from the Centers for Medicare and Medicaid Services (CMS) recommendations against accepting third party premiums. Consistent with CMS guidance, the following are the ONLY acceptable third parties who may pay Ambetter premiums on *your* behalf:

1. Ryan White HIV/AIDS Program under Title XXVI of the Public Health Services Act;

2. Indian tribes, tribal organizations or urban Indian organizations;
3. State and Federal government programs; or
4. *Family members*.

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

Renewal
Subject to the provisions governing payment of Premiums, this *Policy* shall automatically renew from Month to Month for which Premiums are being made.

We will notify *you* 31 days in advance for any rate changes, subject to all regulatory requirements. Notices under this provision will be mailed to the *member's* address of record. We also reserves the right to modify or amend this *Policy* and will provide 60-day advance notice to enrollees before the *effective date* of any material modification. Receipt of premium payments made by the *member* shall constitute acceptance of the modification or amendment.

The *member's* failure to make Premium payment prior to expiration of the *grace period* defined herein shall be cau*s*e for automatic termination of *coverage* under this *Policy*. The date of termination will be the last day of the month for which premium payments have been received in full and accepted by our Accounts Receivable Department.

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

Misstatement of Age
If a *member* misstates the *member's* age, the Premium payable will be as if the *Policy* were purchased at the correct age retroactive to the date the change would have first been effective.

Change or Misstatement of Residence
If *you* change *your* residence, *you* mu*s*t notify the *Federally Facilitated Marketplace* of *your* new residence within 60 days of the change. As a result *your* premium may change and *you* may be eligible for a *Special Enrollment Period*. See the section on *Special Enrollment Periods* for more information.

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

TERMINATION

Termination of Coverage:
This *Policy* may be terminated by *us* upon occurrence of any of the following:

1. If premium payments for the *member* and enrolled *dependents* are not received within the *grace period* defined in this *Policy*, Coverage may automatically terminate. The date of termination will be the last day of the month for which Premium payments have been received and accepted by our Accounts Receivable Department. Refer to the *Reinstatement* heading for further information on how to re-enroll.
2. If a *member* performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of this *Policy*, Coverage for that individual may be terminated. Notice of termination will be provided by *us* and mailed to the *member's* address of record. Acts of fraud or intentional misrepresentation include the following:
   a. knowingly furnishing incorrect or incomplete information to *us* in order to obtain benefits for the *member*, enrolled *dependents*, or a non-enrolled individual; or
   b. allowing another person to *us*e the *your* identification card, or allowing a *member* to *us*e another person's card.

   An individual whose Coverage is terminated under this provision will be prohibited from enrolling under any Plan offered by *us* in the individual market. If a *member's* coverage is terminated under this provision, his enrolled *dependents* may apply for coverage under their own individual plan.
3. If *we* discontinue Coverage for this particular *health plan* in the State of Arizona, coverage under this *Policy* will terminate. A 90 day written notice of termination will be provided by *us* and mailed to the *member's* address of record. The *member*, and his enrolled *dependents*, will have the option of purchasing other health insurance offered by Ambetter in the individual market.
4. If *we* cease to offer Coverage in the individual market in the State of Arizona, Coverage under this *Policy* will terminate. A 180 day written notice of termination will be provided by *us* and mailed to the *member's* address of record.
5. If a *dependent* fails to meet the eligibility requirements, coverage for that *dependent* will terminate without further notice to *member*. The *effective date* for termination under this *Policy* will be the last day of the month in which the qualifying event occurred.
6. Coverage will terminate on the date *we* receive a request from *you* to terminate this Evidence of Coverage or any later date stated in *your* request, or if *you* are enrolled through the *Marketplace*, the date of termination that the *Marketplace* provides *us* or *we* provide the *Marketplace*.

Termination of Membership
We are not responsible for the cost of health care services received by a *member* after the date of termination. If a *member* is confined in a *hospital* or other *inpatient* Facility on the date of termination, Coverage will cease on that date, except as specifically stated as otherwise herein.

If a *member* elects to terminate coverage hereunder, and accepts Coverage under another health plan, *we* will pay expenses for that *member* until midnight on the date the *member's* Coverage is scheduled to terminate.

Cancellation
A *member* desiring to cancel this *Policy* shall provide advance written notice to the *Federally Facilitated Marketplace*, or if an off-exchange *member* by written notice to *us*. Benefits under this *Policy* shall terminate for all *members* on the last day of the month for which cancellation has been requested, or on the last day of the month for which premium payments have been received by *us*, whichever first occurs. In no event will a request for cancellation be processed retroactive to the date for which Premium payment has been received and accepted by Our Accounts Receivable Department. Cancellation of *membe*r's membership will also terminate Coverage for a *member's* enrolled *dependents*.

Refund upon Cancellation
We will refund any premium paid and not earned due to *contract* termination. After the *policy* has been continued beyond its original term, *you* may cancel the *contract* at any time by written notice, delivered or mailed to the Exchange, 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.

Loss of Dependent Eligibility
A *dependent* whose Coverage is terminated for loss of eligibility may apply for Coverage under his own individual plan, provided such *dependent* meets the *member* eligibility requirements, submits a completed and signed Enrollment Application to the *Federally Facilitated Marketplace*, for Exchange coverage, or to *us*, for off-exchange coverage, within 60 days of the termination date of Coverage hereunder, and submits the required Premium payment to *Us*. Coverage shall be in accordance with the rules and regulations that may have in effect at the time such *dependent* applies for individual Coverage. Such rules and regulations may include those relating to Coverage, amount of Premium payment, and all other terms and conditions governing individual membership. Enrollment Applications which are submitted more than 60 days following *dependent's* termination will be subject to Open and *Special Enrollment Periods* and will have an *effective date* in accordance with the rules and regulations in effect at the time of coverage approval.

Rescission of Coverage
We may rescind this *Policy* for any fraudulent or intentional omission or intentional misrepresentation of material facts in the written information submitted by *you* or on *your* behalf on or with *your* enrollment application.

A material fact is information which, if known to *us*, would have caused *us* to decline to issue coverage. If this *Policy* is rescinded, *we* shall have no liability for the provision of coverage under this *Policy*.

By signing the enrollment application, *you* represented that all responses to the Statement of Health were true, complete and accurate, to the best of *your* knowledge, and that should *we* accept *your* enrollment application, the enrollment application would become part of the *Policy* between *us* and *you*. By signing the enrollment application *you* further agreed to comply with the terms of this *Policy*.

If *we* make a decision to rescind *your* coverage, such decision will be first sent for review to an independent third party auditor contracted by *us*.

If this *Policy* is rescinded, *we* will provide a written notice that will:
1. Explain the basis of the decision and *your* appeal rights;

2. Clarify that all *members* covered under *your* coverage other than the individual whose coverage is rescinded may continue to remain covered; and
3. Explain that *your* monthly premium will be modified to reflect the number of *members* that remain under this *Policy*.

If this *Policy* is rescinded:

1. We may revoke *your* coverage as if it never existed and *you* will lose health benefits including coverage for treatment already received;
2. We will refund all premium amounts paid by *you*, less any medical expenses paid by *us* on behalf of *you* and may recover from *you* any amounts paid under the *Policy* from the original date of coverage; and
3. We reserve ours right to obtain any other legal remedies arising from the rescission that are consistent with Arizona law.

If *your* coverage is rescinded, *you* have the right to appeal *our* decision to rescind such coverage.

Construction

This *Policy* has been entered into and delivered, and shall be construed according to the laws of the State of Arizona. For simplicity of expression, pronouns and other terms are sometimes expressed in one number and gender, but where appropriate to the context, these terms shall be deemed to include each of the other numbers and genders. The headings are solely for convenience and shall not affect interpretation.

Reinstatement

We will reinstate a contract when it is erroneously terminated or cancelled. The reinstatement will result in restoration of the enrollment with no break in coverage.

CLAIMS

How to file a claim for Covered Services – Network Providers
Network Providers, also known as In-Network Providers, will file *claims* on *your* behalf with *us* for *covered expenses*. Present *your* identification card at the time of service. Payment for *covered expenses* will be made directly to the *network provider*. *You* will be responsible for *copayment*, *deductibles*, *coinsurance* amounts, any non-Covered or Excluded Expenses, and amounts over specifically limited benefits. Please refer to the Provider Directory for a list of *network providers*.

How to File a Claim for Covered Services - Non-Network Providers
In the case of a medical *emergency* or as *authorized* by Ambetter, *you* may need to get care from *non-network providers*. *Providers* who do not have an agreement with *us,* may or may not file *your claim* with *us*. If they do not, send a copy of *your* paid itemized bill to *us*, along with a completed *claim* form which can be obtained from *our* website *us*. Payment of the billed expense amount for *covered services*, as defined in this *Policy*, will be paid to *you* subject to applicable *copayment*s, *deductibles* and *coinsurance* amounts, unless *we* are directed otherwise, or as required by applicable state or federal law. *You* will be responsible for *copayment*s, *deductibles*, *coinsurance* amounts, any non-Covered or Excluded Expenses, and amounts over specifically limited benefits.

C**laims should be addressed to:**
Ambetter from Health Net
ATTN: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

Payment of Claims
Time of payment of *claims*: Indemnities payable under this *Policy* for any *loss* other than *loss* for which this *Policy* provides any periodic payment, will be paid immediately upon receipt of due written proof of such *loss*, and no later than 30 days from an acceptable proof of loss.. Subject to due written proof of loss, all accrued indemnities for *loss* for which this *Policy* provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Physical Examination and Autopsy
We have the right to have any *member* examined at *our* expense while a *claim* is pending payment. *We* also have the right to have an autopsy performed where it is not prohibited by law. These examinations are made at *our* expense and as often as *we* may reasonably require.

Double Coverage
In the event that an individual is both enrolled as a *member* under this *Policy* and entitled to benefits under any of the conditions described below, *our* responsibility for services and supplies provided to the *member* for the treatment of any one *illness* or *injury* shall be reduced by the amount of benefits paid, or the reasonable value of the services or supplies received, without any liability for the cost thereof, for the treatment of that same *illness* or *injury* as a result of the *member's* entitlement to payment for such services and supplies from any other source.

This provision is applicable to any service and supplies, including room and board, provided to the *member* by any federal or state governmental agency, or by any municipality, county or other political subdivision. This provision shall not apply to:

a. Any medical assistance benefits and services to which a *member* is entitled pursuant to the Arizona medical assistance program; or
b. *Covered Services* received by a veteran Member in a Veterans Administration or armed forces Facility as required by federal law.

Med Pay Insurance
If a *member* is injured as a result of a motor vehicle *accident*, *we* will arrange for *medically necessary* services. In such event, the *member* is responsible to reimburse *us* for the reasonable expenses actually incurred by *us* for necessary medical treatment actually provided to the *member* to the extent that the *member* receives payment and/or reimbursement for such treatment under a medical payment provision of an automobile insurance policy. *We* reserve the right to pursue legal remedies available for recovery of funds which are duplicated under the provisions of a Member's Med Pay automobile insurance policy.

Member must take any actions necessary which include, but are not limited to, providing information, completing and submitting consents, releases, assignments, and other documents to assist *us* in enforcing its rights under this provision.

Right to Receive and Release Information
We may release or receive any information considered to be necessary for *us* to coordinate benefits with respect to any person claiming benefits under this *Policy* and without any additional consent, or notice to, the *member* or any other person or organization. *We* shall not, however, be required to determine the existence of any other group *payor* or insurer or the benefits payable under such *payor* or insurer when computing *covered services* due a *member* under this *Policy*.

Recovery of Overpayment
If the *covered services* provided by *us* exceed the total amount of benefits that should have been paid under this section, *we* have the right to recover from one or more of the following:

1. Any person to or from whom such payments were made; or
2. Insurance companies.

Facility of Payment
Payment(s) made under another Plan, which included amounts that should have been paid by *us*, shall be reimbursed to that entity and treated as though it was a benefit paid under this Plan. *We* will not be required to pay that amount again. The term *payment(s) made* shall include providing benefits in the form of services, in which case *payment(s) made* will be interpreted as the reasonable cash value of the benefits provided in the form of services.

Medicare
This provision describes how *we* coordinate and pay benefits when a *member* is also enrolled in Medicare and duplication of Coverage occurs. If a *member* is not enrolled in Medicare or receiving benefits, there is no duplication of Coverage and *we* do not have to coordinate with Medicare.

The benefits under this *Policy* are not intended to duplicate any benefits to which *members* are entitled under Medicare. All sums payable under such programs for services provided shall be payable to and retained by *us*. Each *member* shall complete and submit to *us* such consents, releases, assignments and

other documents as *we* may request in order to obtain or assure reimbursement under Medicare or any other government program for which *members* are eligible. In cases where Medicare or another government program (excluding Arizona AHCCCS) has primary responsibility, Medicare benefits will be taken into account for any *member* who is enrolled for Medicare. This will be done before the benefits under this *health plan* are calculated.

Charges for services used to satisfy a *member's* Medicare Part B deductible will be applied in the order received by *us*. Two or more expenses for services received at the same time will be applied starting with the largest first.

Any rules for coordination of benefits will be applied after benefits have been calculated under the rules in this provision. The allowed amount, which is either the contracted amount or the Maximum *allowable expenses* will be reduced by any Medicare benefits available for those expenses.

This provision will apply to the maximum extent permitted by federal or state law. *We* will not reduce the benefits due any *member* because of a *member's* eligibility for Medicare where federal law requires that *we* determine its benefits for that *member* without regard to the benefits available under Medicare.

Health Care Liens
When there is a source of payment for a Covered Service in addition to the *coverage* provided by *us*, such as, for example, a liability insurer, government payer or uninsured and/or underinsured motorist coverage *network providers* may collect from that other source any difference between the negotiated amount of payment agreed upon between *us* and the *network provider* for a Covered Service and the *network provider's* customary charge, by following the procedures set forth in Arizona law (A.R.S. Sec. 33-931).

Worker's Compensation
The benefits which a *member* is entitled to receive under this *Policy* are not designed to duplicate any benefits to which the *member* is entitled under workers' compensation law. *We* are entitled to reimbursement for any services that have been reimbursed under a workers' compensation claim.

1. *Member* is required to file for workers' compensation when an employment related *accident*, *illness* or *injury* occurs.
2. If the *member's* workers' compensation carrier denies a claim, the *member* may submit the claim to *us* with a copy of the denial for consideration under this *Policy*. All plan provisions of this *Policy* will apply in the consideration process for payment under this plan.
3. Workers' compensation Claims that are not a benefit under this *Policy* are not payable by *us*.
4. Any benefits payable are subject to all provisions of this *Policy*, including but not limited to the *authorization* requirements.

INTERNAL GRIEVANCE, INTERNAL APPEALS, AND EXTERNAL APPEALS PROCEDURES

GRIEVANCE AND APPEALS PROCEDURES
A *member* may, on occasion, be dissatisfied with quality of care, service issues, or the denial of a *claim* or request for service. Dissatisfaction with quality of care or service may be filed as a grievance**.** Dissatisfaction with the denial of a *claim* or request for service may be filed as an appeal. Below is a brief description of each process. Please see *your* separate information package titled *How to File Grievance and Appeals* for a full description of the filing process and the different levels of appeal available to *you*.

YOUR SATISFACTION IS AMBETTER'S CONCERN
At Ambetter from Health Net, *we* want *you* to be pleased with the quality of care and service *you* receive. Surveys show that most of Health Net's Members are satisfied and many stay with *us* year after year. *We* hope *you* are one of those Members. If not, *we* want to hear from *you* so *we* can improve.

Anytime *you* have a concern about the quality of care *you* receive, the level of *our* service or any other aspect of *your health plan* – *we* want to know. Call *us* toll free at 1-888-926-5057 (TTY/TDD 1-888-926-5180). Many times, a single phone call to Member Services staff can make things right.

In addition to calling Member Services, there are other avenues for *you* to use if *you* do not agree with a decision made by *us* or by one of the health care professionals who work with *us*. Like *you*, we want to be sure the appropriate decisions are made regarding *your* medical care and that *you* receive the benefits *your health plan* covers.

SHOULD YOU FILE A GRIEVANCE OR AN APPEAL?

Grievance
You initiate a grievance when *you* are not satisfied with the quality of care or service *you* are receiving. A grievance is the first step *you* take to tell *us* that we are not meeting *your* expectations. A grievance tells *us* that *you* are not pleased with the quality of medical care or the service that *you* received. A grievance brings *your* concern to our attention.

We want *you* to let *us* know how we can improve any aspect of *your* medical care, preventive health benefits, customer service or *your* understanding of *your* health plan. Call, write or fax *your* grievance to *us*. *We* will acknowledge receiving *your* grievance within five days. *You* will receive a decision within 30 days. Occasionally, *we* may take an extra 15 days to receive and review information before we send *you* our decision. Every grievance about the quality of medical care is taken seriously. That's why we have a Quality Improvement Department for investigation and follow-up with the doctor or *facility* that provided the care.

Appeal
You file an appeal in response to a denial received from *us*. This could be a denial of *coverage* for requested medical care or for a *claim you* filed for care already received. An appeal asks *us* to review *your* request for *coverage* of medical care or *claim* for reimbursement. *Your* appeal goes to people who have not reviewed *your* case before. *You* can call, write or fax *your* request to start the appeal process.

You will want to know that medical information is reviewed by *physicians* at every level – from *your Primary Care Physician*, to a *referral specialist*, other doctors in the medical group and *our* medical direc-

tors. The type of care requested must be *medically necessary* – and it must be a service or treatment that is covered by *your* health plan.

In many cases, *you* can present the specifics of *your* initial appeal by phone.

How to File Grievance and Appeals packet was delivered with *your policy*. In addition, *you* may request additional copy by contacting *us* by phone, mail, or fax with the contact information below.

TO GET STARTED

Phone

You can initiate either the appeal or grievance process by phone. Just call Member Services *us*, Monday through Friday from 7 a.m. to 6 p.m. at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

Mail

You can mail a written appeal or grievance to:
Ambetter from Health Net of Arizona, Inc.
Commercial Appeals and Grievances Dept.
P.O. Box 277610
Sacramento, CA 95827-7610

Fax

You may also fax a written appeal to the Ambetter Appeals and Grievances Department at 1-877-615-7734.

OTHER APPEAL & GRIEVANCE INFORMATION

General Eligibility Appeals and Premium Disputes

We do not review any disputes regarding eligibility and/or premiums for policies purchased through the Market Place. However, under Federal law, *you* and *your* health care decision-maker have the right to file an appeal within a reasonable timeframe regarding *your* eligibility, which may include a determination of *your* eligibility for an enrollment period, including for *Special Enrollment Periods*. *You* may also file any disputes regarding *your* premiums or premium assistance directly to the Market Place. *You* may contact the Market Place by telephone at 1-800-318-2596 or 1-855-889-4325 (TTY: 711), which is available 24 hours a day, 7 days a week. *You* may send *your* written appeal by fax to 1-877-369-0129 or by mail to:

Health Insurance Marketplace
Attn: Appeals
465 Industrial Blvd
London, KY 40750-0061

After the Market Place reviews *your* appeal and *you* do not agree with their decision, *you* have an additional right to appeal that decision through the U.S. Department of Health and Human Services (HHS). *You* must file *your* appeal to the HHS within 30 days of the Market Place's notice to *you* of their appeal decision. *You* may contact the HHS at their Toll Free Call Center: 1-877-696-6775.

You may find additional information regarding *your* appeal rights through the Market Place's website at: https://www.healthcare.gov/contact-us/ and/or through the HHS' website at http://www.hhs.gov/healthcare/.

Getting Your Medical Records
Under Arizona law, *you* and *your* health care decision-maker are entitled to a copy of *your* medical records from any health care professional that has treated *you*. Make *your* request in writing and be sure to include the address where *you* want *your* records sent. In some cases, *your* records will be sent only to the medical professional that *you* have designated.

Confidential Medical Information
Your medical records are confidential. They are used only as needed to make decisions about *your* care – or any appeals *you* may file. During an appeal, Health Net may release some portions of *your* medical records to the people who are reviewing *your* case.

Mailing Documents
We wants to be sure *our* response reaches *you*. Please confirm that *we* have *your* current mailing address in *our* records because that is where documents will be sent. *We* consider information mailed to *you* to be received on the fifth business day.

The Role of the Director of the Arizona Department of Insurance
The Director of the Arizona Department of Insurance will oversee this appeals process. The Director will maintain a copy of each health plan's *utilization review* policy; receive, process, and act on requests from health plans for External Independent Review; review and enforce or overturn the decisions of the health plans; and file appropriate reports with the Arizona Legislature. When necessary, the Director must transmit appeal records to the Superior Court or the Office of Administrative Hearings and issue final administrative decisions.

Questions
If *you* have questions or need assistance, please call Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

Medical Malpractice Disputes
Any disputes alleging the medical malpractice, negligence and/or wrongful act of a health care *provider*, or *injury* or property damage caused as a result of an *accident* at the premises of a health care *provider*, shall not include *us* and shall include only the *provider* subject to the allegation. Ambetter from Health Net, and Plan *providers* are independent contractors in relation to one another.

Access to Medical Records
We are entitled to receive from any *provider* who renders *covered services* to a *member* all information reasonably related to such services. Subject to applicable confidentiality requirements, *members authorize* any *provider* rendering *covered services* to disclose all facts pertaining to the *member's* care and treatment by the *provider* and to permit copying of reports and records by *us*. *Member* agrees to execute a release and/or *authorization* for *us* to obtain medical records if requested by *us* during the term of the *member's coverage*. *We* reserve the right to reject or suspend a *claim* based on lack of medical information or records.

Confidentiality
We shall preserve the confidentiality of the *members*' health and medical records consistent with the requirements of applicable Arizona and federal law.

Records
We keep records of all *members*, but are not liable for any obligation dependent upon information from the *member* prior to its receipt in a form satisfactory to *us*. If *we* have not acted to *our* prejudice by relying thereon, incorrect information furnished by the *member* may be corrected.

GENERAL PROVISIONS

Entire Agreement
This *Policy*, the Schedule of Benefits, and the individual Enrollment Application, including any attachments, constitute the entire Agreement between Ambetter from Health Net and the *member*, and supersede all prior and existing arrangements, understandings, negotiations, and discussions, whether written or oral, of the parties. There are no warranties, representations, or other agreements between *us* and the *member* in connection with the subject matter of this *Policy*, except as specifically set forth herein. No supplement, modification or waiver of this *Policy*, other than as specifically provided for herein, shall be valid unless executed in writing by the President of Health Net of Arizona or an authorized executive officer of Health Net of Arizona. No agent has authority to change this *Policy* or to waive any of its provisions.

Time Limit on Certain Defenses
After two years from the date of issue of this *Policy* no misstatements, except fraudulent misstatements, made by the *member* in the Enrollment Application shall be used to void the *Policy* or to deny a *claim* for *loss* incurred or Disability commencing after the expiration of such two year period.

No *claim* for *loss* incurred or Disability commencing after two years from the date of issue of this *Policy* shall be reduced or denied on the ground that a disease or physical condition not excluded from *coverage* by name or specific description effective on the date of *loss* had existed prior to the *effective date* of *coverage* of this *Policy*.

Independent Contractor Services
We do not ourselves undertake to directly furnish any health care services under the Agreement. *We* reserve the right to add or delete *network providers* from *our provider* panel.

The relationship between *us* and *network providers*, *physicians*, *Skilled Nursing Facilities*, *networks*, other *health professionals*, and other community agencies, is that of independently contracting entities. Such independently contracting entities are neither agents nor employees of Health Net nor is Health Net or any employee of Health Net an employee or agent of such entities. *We* shall not be liable for any *claim*, demand or cause of action regarding damages arising out of, or in any manner connected with, any injuries, alleged or otherwise, suffered by the *member* while receiving care in, from, or through any such entities.

Acceptance Of The Agreement
The *member* enters into this Agreement on behalf of himself and any enrolled *dependents* who become Members of Ambetter. Acceptance of this *Policy* by the *member* constitutes acceptance by his enrolled *dependents* and is binding on all *members*. By electing medical and *hospital coverage* pursuant to his *Policy*, or accepting benefits hereunder, all *members* legally capable of contracting, and the legal representatives of all *members* incapable of contracting, agree to all terms, conditions and provisions of this *Policy*.

Amendment or Modification
This *Policy* shall be subject to amendment, modification or termination in accordance with the provisions hereof. *We* will provide the *member* 60 day prior written notification of any amendment or material modification to this *Policy*, including the *Schedule of Benefits*. Notice will be sent to the *member's* address

of record. Receipt of Premium payment by will constitute the *member's* acceptance of the amendment or modification. Consent of enrolled *dependents* is not required. The *member's* failure to make Premium payment will automatically terminate *coverage* under this *Policy*. The date of termination will be the last day for which Premium payment has been received and accepted by *our* Accounts Receivable Department.

Policies and Procedures
We have adopted policies, procedures, rules and interpretations to promote orderly and efficient administration of the Agreement, and, in *our* discretion, may Amend, modify, terminate, or adopt other policies, procedures, rules and interpretations. Consent or concurrence of the *member*, or enrolled *dependents*, is not required. At *our* sole discretion and without obligation under this Health Plan, *we* may offer to provide a *member* alternative coverage for services and supplies which may be otherwise excluded or limited by the terms of this *Policy*. Such alternative coverage is available only where Ambetter and the *member*, or the *member's* legal representative, agree in writing to the alternative treatment. All alternative treatment is subject to the determination by the *member's* treating *provider* that the alternative treatment plan is appropriate for the *member*. In no event shall the cost of alternative coverage exceed the cost of *covered services* to which the *member* would otherwise be entitled.

Commencement Or Termination
Whenever an effective date of commencement or termination is provided, such commencement shall be effective as of 12:01 a.m. of that date in Arizona. Termination shall be effective as of 11:59 p.m. of that date in Arizona.

Policy
We will deliver to each *member* a copy of this *Policy*, including the *Schedule of Benefits,* which sets forth the terms and conditions governing the rights of such *member* and *dependents*.

Clerical Inaccuracies
Clerical error by *us* in keeping any record pertaining to *coverage* hereunder, will not invalidate *coverage* otherwise validly in force or continue *coverage* otherwise validly terminated.

Any notice to a *member*, or an enrolled *dependent*, shall be sufficient if the notice is addressed to the *member* at the address last appearing on *our* records.

Assignment
All rights of *members* hereunder are personal to each *member* and are not assignable or otherwise transferable. Neither the Agreement nor any right hereunder shall be assigned, transferred or otherwise conveyed by *us* without the approval of *us*. If a *member* desires to assign any rights hereunder, such request shall be evidenced in writing signed by the *member* and will be granted or denied at *our* sole discretion. Nothing herein shall be construed to prohibit *us* from engaging in a corporate reorganization or merger without the consent of the *member*.

Severability
If any term, provision, covenant or condition of this *Policy* is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions shall remain in full force and shall in no way be affected, impaired or invalidated.

Implied Waiver
Failure by *us* on one or more occasion to avail itself of a right conferred by this *Policy* shall in no event be construed as a waiver of its right to enforce said right in the future. Should *we* provide a *member* with *coverage* for benefits to which the *member* is not entitled under this *Policy*, such provision of *coverage* shall not amend this *Policy* to incorporate those benefits herein or entitle the *member* to receive additional benefits not specifically listed under this *Policy*.

Events Not In Our Control
To the extent that a disaster, war, riot, civil insurrection, epidemic or other *emergency* or event not within the control of *our* results in the offices, personnel, or financial resources of *us* being unable to provide or arrange for the provision of *covered services* and benefits, *we* shall have no liability or obligation for any delay in the provision of or failure to provide such services and benefits, except that *we* shall make a good faith effort to provide such services, taking into account the impact of the event.

IMPORTANT NOTICES

Notice of Privacy Practices:

Health Net knows that personal information in your medical records is private. Health Net provides Members with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access and to request amendments, restrictions and an accounting of disclosures of protected health information; and the procedures for filing complaints. Members receive the Notice of Privacy Practices in the new Member Welcome Packet. However, you may also obtain a copy of Health Net's Notice of Privacy Practices on the website at www.ambetterhealthnet.com or through Health Net's Net Member Services at the number listed on the back of Your Health Net ID card.

Women's Health and Cancer Rights Act of 1998:

Surgical services for breast reconstruction and for post-operative prostheses incidental to a Medically Necessary mastectomy are covered. Coverage includes:

- 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 physical complications for all stages of mastectomy, including lymphedemas and at least two external postoperative prostheses subject to all of the terms and conditions of the policy.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Non-Discrimination

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

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).

- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Ambetter from Health Net at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

If you believe that Health Net 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 by calling the number above and telling them you need help filing a grievance; Member Services 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, (TDD: 1-800–537–7697).

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

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Health Net, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-926-5057 (TTY: 711).
Navajo:	Ni da éí doodago háida bíká anilyeedígíí Ambetter from Health Net yina'idilkidgo t'áá ni nizaad k'ehjí níká a'doowoł dóó hazhó'ó bee nił hodoonihgo bee ná haz'ą́ dóó bą́ąh ílínígóó. Ata' halne'igíí la' bich'į' hadeesdzih ninízingo koji' hólne' 1-888-926-5057 (TTY: 711).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Health Net 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 1-888-926-5057 (TTY: 711)。
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Health Net, 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 1-888-926-5057 (TTY: 711).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Health Net ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-888-926-5057 (TTY: 711).
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Health Net, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-888-926-5057 (TTY: 711).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Health Net 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-888-926-5057 (TTY: 711) 로 전화하십시오.
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Health Net, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-888-926-5057 (TTY: 711).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Health Net 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 1-888-926-5057 (TTY: 711) an.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Health Net вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-888-926-5057 (TTY: 711).
Japanese:	Ambetter from Health Net 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、1-888-926-5057 (TTY: 711) までお電話ください。
Persian:	اگر شما، یا کسي که به او کمک مي کنید سؤالي در مورد Ambetter from Health Net دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. براي صحبت کردن با مترجم با شماره 1-888-926-5057 (TTY: 711) تماس بگیرید.
Syriac:	ان اللوخن خورنه ميقورى المساعدة يمصيتون متلفتلن الدوا مشى Ambetter from Health Net يمصيوت ميقريوتن المساعدة.. وختي لا شقلخ زوزة منوخن . ان اللوخون بارا الآتي مندي .وان مترجم رقم تلفون 1-888-926-5057 (TTY: 711)
Serbo-Croatian:	Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from Health Net, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-888-926-5057 (TTY: 711).
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับ Ambetter from Health Net ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-888-926-5057 (TTY: 711).