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2018 Evidence of Coverage

Ambetter.HomeStateHealth.com

99723MO0009

Ambetter from Home State Health
Individual EPO Health Benefit Plan
Issued and Underwritten by Celtic Insurance Company

Home Office: 16090 Swingley Ridge Road, Suite 500, Chesterfield, MO 63017

Individual Member Contract

In this *contract, "you", "your", "yours" or "member"* will refer to the subscriber and/or any *dependents* named on the *schedule of benefits* and *"we," "our,"* or *"us"* will refer to Home State Health.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. *We* will provide benefits to *you*, the *member*, for covered *losses* due to *illness* or bodily *injury* as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all contracts issued on this form, with the same type and level of benefits, to residents of the state where *you* then live; (2) we withdraw from the *service area* or reach demonstrated capacity in a *service area* in whole or in part; or (3) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a *claim* for *contract* benefits. In addition, we may discontinue this *contract* if: (1) *you* fail to pay premiums in accordance with the terms of this *contract* or *we* do not receive timely premium payments; or (2) *you* no longer reside, live, or work in the *service area* or in an area in which *we* are authorized to do business.

From time to time, *we* will change the rate table used for this *contract* form. Each premium will be based on the rate table in effect on that premium's due date. The *policy* plan, and age of *members,* type and level of benefits, and place of *residence* on the premium due date are some of the factors used in determining *your* premium rates. We have the right to change premiums however, all premium rates charged will be guaranteed for a rating period of at least 12 months.

At least 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 *contract* or a change in a *member's* health. While this *contract* is in force, *we* will not restrict coverage already in force.

This health benefit plan requires that all health care services be delivered by a participating provider in *our network*. Services rendered by an out-of-*network* provider are not covered under this plan, except for *emergency services* and two (2) sessions per year to a licensed psychiatrist, licensed psychologist, licensed professional counselor or a licensed clinical worker for the purpose of diagnosis or assessment of mental health.

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

WARNING: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

TEN DAY RIGHT TO RETURN CONTRACT

Please read your *contract* carefully. If you are not satisfied, return this *contract* to us or to our agent within 10 days after you receive it. All premiums paid will be refunded, less claims paid, and the *contract* will be considered null and void from the *effective date*.

IMPORTANT INFORMATION

This *contract* reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the US Department of Health and Human Services, and the Missouri Department of Insurance, Financial Institutions and Professional Registration., those changes will be incorporated into your health insurance *contract*.

The coverage represented by this *contract* is under the jurisdiction of the Missouri Department of Insurance, Financial Institutions and Professional Registration.

This contract does not include pediatric dental services. Pediatric dental coverage is included in some health plans, but can also be purchased as a standalone product. Please contact your insurance carrier or producer, or seek assistance through Healthcare.gov, if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

Should this *contract* be purchased Off the Exchange, then any and all references to Exchange or Marketplace are not applicable.

Celtic Insurance Company

Anand Shukla,
SVP, Individual Health – Celtic Insurance Company

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INTRODUCTION

Welcome to Ambetter from Home State Health! This *contract* is issued and underwritten by Celtic Insurance Company, and network access and administrative services are provided by Home State Health. This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services. It describes:

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

This *contract*, the *schedule of benefits*, application as submitted to the exchange, and any amendments or riders attached shall constitute the entire contract under which *covered services and supplies* are provided or paid for by *us*.

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

How to Contact Us
Ambetter from Home State Health
16090 Swingley Ridge Road
Suite 500
Chesterfield, MO 63017

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

Member Services	855-650-3789
TDD/TTY	877-250-6113
Emergency	911
24/7 Nurse Advice Line	855-650-3789

Interpreter Services
Ambetter from Home State Health 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 1-855-650-3789 (TDD/TTY 1-877-250-6113).

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 health care consumer.
4. Providing access to *covered services* and *our network providers*.
5. Sharing *our* expectations of *you* as a *member*.
6. Providing coverage regardless of age, ethnicity or race, religion, gender, sexual orientation, national origin, physical or mental disability, and/or expected health or genetic status.

You have the right to:

1. Participate with *your providers* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding *member's* rights, responsibilities and policies.
9. Voice *complaints* or *appeals* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. See *your* medical records.
12. 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 31 days before the *effective date* of the modifications. Such notices shall include the following:
    a. Any changes in clinical review criteria; or

b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.

13. A current list of *network providers*.
14. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
15. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
16. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
17. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
18. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
19. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
20. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
21. An interpreter when *you* do not speak or understand the language of the area.
22. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not *authorizing* the requested care, or if *you* want more information about *your* treatment.
23. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
24. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help your *primary care physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    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* should establish a relationship with *your physician*. You may change your *primary care physician* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or

ask for help if *you* need it.

8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. 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 must tell us.
15. Pay *your* monthly premium on time and pay all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.
16. 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 http://ambetter.homestatehealth.com/findadoc. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. *You* may find any of our *network providers* by completing the "Find a Provider" function. There *you* will have the ability to narrow *your* search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. *Your* search will produce a list of providers based on *your* search criteria and will give *you* other information such as address, phone number, office hours, and qualifications.

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-855-650-3789. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. We* can also help *you* pick a *primary care physician* (PCP). We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If *you* need help, call Member Services at 1-855-650-3789. *We* will help *you* make the appointment.

Your Member ID Card

When *you* enroll, *we* will mail a member ID card to *you* after *our* receipt of *your* completed enrollment materials, which includes receipt of *your* initial premium payment. This card is proof that *you* are enrolled in the Ambetter from Home State Health and is valid once your initial premium 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 this *contract*.

The ID card will show *your* name, *member* ID#, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-855-650-3789. *We* will send *you* another card.

Our Website

Our website helps *you* get the answers to many of *your* frequently asked questions and has resources and features that make it easy to get quality care. *Our* website can be accessed at ambetter.homestatehealth.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 status 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.
7. Our Formulary or Preferred Drug List.
8. Selecting a *Primary Care Provider*.
9. *Deductible* and *Co-payment* Accumulators.
10. Making your payment.

If you have material modifications (examples include a change in life event (marriage, death) or family status), or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Quality Improvement

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

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

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

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

DEFINITIONS

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

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

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

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

1. A denial of a request for service.
2. A denial, reduction or failure to provide or make payment in whole or in part for a covered benefit.
3. 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.
4. A determination that a service is *experimental, investigational, cosmetic treatment,* not *medically necessary* or inappropriate.
5. *Our* decision to deny coverage based upon an eligibility determination.
6. A *rescission* of coverage determination as described in the General Provisions section of this *contract.*
7. 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 Internal Grievance, Internal Appeals and External Appeals Procedures section of this *contract* for information on your right to appeal an *adverse benefit determination*.

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

Alcoholism Treatment Facility means a residential or nonresidential facility certified by the Missouri Department of Mental Health for treatment of alcoholism.

Applied behavior analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorder means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise

Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association

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

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 service expenses.*

Bereavement counseling means counseling of members of a deceased person's *immediate family* that is designed to aid them in adjusting to the person's death.

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*.

Center of Excellence means a *hospital* that:

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

Chemical dependency means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

Claimant is the *member* or *member's* authorized representative who has contacted the plan to file a grievance or appeal or who has contacted the Missouri Department of Insurance to file an external review.

Coinsurance means the percentage of *covered service expenses* that *you* are required to pay when *you* receive a service. C*oinsurance* amounts are listed in the *schedule of benefits*. Not all *covered services* have *coinsurance*.

Coinsurance percentage means the percentage of *covered service expenses* that are payable by *you*.

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

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

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

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

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

Cosmetic treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury*, *illness*, or congenital anomaly. *Cosmetic treatment* does not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect.

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 Indian enrolled in a *QHP* in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

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

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

Custodial Care is treatment designed to assist a *member* with activities of daily living and which can be

provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial care includes (but is not limited to) the following:

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

Deductible amount 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.*

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

Dependent member means *your* lawful *spouse, civil union partner* and/or an *eligible child*, by blood or law, who is under age 26*.*

Durable medical equipment means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*, can withstand repeated use, are generally not useful to a person in the absence of *illness* or *injury*, and are appropriate for use in the patient's home.

Effective date means the applicable date a *member* becomes covered under this *contract* for *covered services*.

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

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

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

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

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

    Please note: You may be billed for the difference between the amount paid and the non-*network provider's* charge.

    b. When a *covered service expense* is received from a *non-network provider* as approved or *authorized* by *us* that is not the result of an *emergency*, and there is a sufficient number and type of *network providers* to provide a *covered service*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* as payment in full (*you* will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the provider with *us,* the *eligible service expense* is the amount that would be paid under Medicare (*you* may be billed for the difference between the amount paid under Medicare and the provider's charge).
    c. When a *covered service* is received from a *non-network provider* and there is an insufficient number or type of *network providers* to provide a *covered service*, regardless of whether it is the result of an *emergency*, the *eligible service expense* is the lesser of (1) the negotiated fee, if any, that has been mutually agreed upon by *us* and the provider; or (2) the amount accepted by the 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.

Emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:
(a) Placing the person's health in significant jeopardy;
(b) Serious impairment to a bodily function;
(c) Serious dysfunction of any bodily organ or part;
(d) Inadequately controlled pain; or
(e) With respect to a pregnant *member* who is having contractions:
a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
b. That transfer to another hospital may pose a threat to the health or safety of the pregnant *member* or unborn child;

Emergency service means a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are

provided in a licensed hospital's emergency facility by an appropriate provider.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories: Ambulatory patient services, *Emergency* services, Hospitalization, Maternity and newborn care, Mental health and *substance use disorder* services, including behavioral health treatment, Prescription drugs, Rehabilitative and habilitative services and devices, Laboratory services, Preventive and wellness services, and chronic disease management and pediatric services, including oral and vision care. *Essential Health Benefits* provided within this *contract* are not subject to lifetime or annual dollar maximums.

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

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

Items (3) and (4) above do not apply to phase III or IV *USFDA* clinical trials.

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

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

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

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

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

Grievance means a written *complaint* submitted by or on behalf of an enrollee regarding the:

1. Availability, delivery or quality of health care services, including a *complaint* regarding an adverse determination made pursuant to utilization review;
2. Determination to rescind a *contract*;
3. Claims payment, handling or reimbursement for health care services; or
4. Matters pertaining to the contractual relationship between an enrollee and a health carrier;

Habilitation or ***Habilitation Services*** means health care services that help *you* keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* or *outpatient* settings.

Hearing care professional means a person who is a licensed audiologist, a licensed hearing instrument dispenser, or a licensed *physician*.

Hearing instrument or ***hearing aid*** means any instrument or device designed, intended, or offered for the purpose of improving a person's hearing and any parts, attachments, or accessories, including ear molds. Batteries, cords, and individual or group auditory training devices and any instrument or device used by a public utility in providing telephone or other communication services are excluded.

Hearing instrument dispenser means a person who is a *hearing care professional* that engages in the selling, practice of fitting, selecting, recommending, dispensing, or servicing of hearing instruments or the testing for means of hearing instrument selection or who advertises or displays a sign or represents himself or herself as a person who practices the testing, fitting, selecting, servicing, dispensing, or selling of hearing instruments.

Home health aide services means those services provided by a home health aide employed by a *home health care agency* and supervised by a registered nurse, which are directed toward the personal care of a *member.*

Home health care means care or treatment of an *illness* or *injury* at the *member's* home that is:

1. Provided by a *home health care agency*; and
2. Prescribed and supervised by a *physician*.

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

1. Operates pursuant to law as a *home health care agency*;
2. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;
3. Maintains a daily medical record on each patient; and
4. Provides each patient with a planned program of observation and treatment by a *physician,* in accordance with existing standards of medical practice for the *injury* or *illness* requiring the *home health care.*

Hospice means an institution that:

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

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

Hospital means an institution that:

1. Operates as a *hospital* pursuant to law;
2. Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients*;
3. Provides 24-hour nursing service by registered nurses on duty or call;
4. Has staff of one or more *physicians* available at all times;
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care facility; an *extended care facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional facility, or *residential treatment facility;* a place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

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

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

Injury means accidental bodily damage sustained by a *member* that is the direct cause of the condition for which benefits are provided, independent of disease or body infirmity or any other cause that occurs while this *contract* is in force. All *injuries* due to the same accident are deemed to be one *injury*.

Inpatient means that services, supplies, or treatment for medical, behavioral health and substance abuse, are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

Intensive care unit means that part of a hospital service specifically designed as an *intensive care unit* permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available in other hospital rooms or wards, the care to include close observation by trained and qualified

personnel whose duties are primarily confined to the part of the hospital for which an additional charge is made.

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.

Listed transplant means medically necessary human organ and tissue transplants including the following:

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

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

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service

area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), however this will not apply to a dependent living outside the service area if a court order requires the member to cover the dependent ;

3. In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
4. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.
5. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.
6. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

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

Manipulative Therapy means treatment applied to the spine or joint structures to correct vertebral or joint malposition and to eliminate or alleviate somatic dysfunction including, but not limited to, manipulation, myofacial release or soft tissue mobilization. Treatment must demonstrate pain relief and continued improvement in range of motion and function and cannot be performed for maintenance care only. *Manipulative therapy* is not limited to treatment by manual means.

Maximum out-of-pocket amount is the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *and copayment amount* and *coinsurance* percentage of *covered service expenses*, as shown in the *schedule of benefits*. After the *maximum out-of-pocket amount* is met for an individual, Ambetter from Home State Health pays 100% of *eligible 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 one or more covered persons' *eligible expenses*. 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*.

Maximum therapeutic benefit means the point in the course of treatment where no further improvement in a *member's* medical condition can be expected, even though there may be fluctuations in

levels of pain and function.

Medical practitioner includes but is not limited to a *physician*, nurse anesthetist, *physician*'s assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *contract:* rolfer, hypnotist, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

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

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

Medically stabilized means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*.

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

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

Mental disorder 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).
Necessary medical supplies mean medical supplies that are:

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

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

Network means a group of *medical practitioners* and providers who have contracts that include an agreed upon price for health care services or expenses.

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* health services even if provided by a non-*network provider*.

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

Non-elective caesarean section means:
1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

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

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

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

Outpatient Contraceptive Services means consultations, examinations, and medical services, provided on an *outpatient* basis and related to the use of contraceptive methods to prevent *pregnancy* which has been approved by the U.S. Food and Drug Administration.

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

Period of extended loss means a period of consecutive days:
1. Beginning with the first day on which a *member* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient.*

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

Physician means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law. A *physician* does NOT include someone who is related to a *member* by blood, marriage or adoption or who is normally a member of the *member's* household.

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

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

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

Prescription drug deductible amount means the amount of *covered service expenses*, shown in the *schedule of benefits*, if applicable, that must actually be paid during any *calendar year* before any *prescription drug* benefits are payable. The family *prescription drug deductible amount* is two times the individual *prescription drug deductible amount*. For family coverage, once a *member* has met the individual *prescription drug deductible amount*, any remaining family *prescription drug deductible amount* can be met with the combination of any one or more *member*' *eligible expenses*.

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

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

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

Prosthetic device means an artificial limb device to replace, in whole or in part, a leg or arm.

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

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

Qualified Individual means, with respect to a Health Insurance Marketplace, an individual who has been determined eligible to enroll through the Health Insurance Marketplace in a *qualified health plan* in the individual market.

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

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

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

1. Is licensed by the state as a *rehabilitation facility*; and

2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care*,* or for care of the mentally incompetent.

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

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

Rescission of a *contract* means a determination by an insurer to withdraw the coverage back to the initial date of coverage.

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

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

1. Is not a *hospital, extended care facility,* or *rehabilitation facility;* or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

Scalp Hair Prostheses means artificial substitutes for scalp hair that are made specifically for a specific *member*.

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*.

Respite care means home health care services provided temporarily to a *member* in order to provide relief to the *member's immediate family* or other caregiver.

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

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

Spouse means *your* lawful wife or husband.

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

Substance abuse or ***substance use disorder*** means alcohol, drug or chemical abuse, overuse, or dependency.

Covered *substance abuse disorders* are those listed in the most recent edition of the International Classification of Diseases, Tenth Revision (ICD-10).

Surgery or ***surgical procedure*** means:

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

Surveillance tests for ovarian cancer means annual screening using:

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

Telemedicine services means health care services delivered by use of interactive audio, video, or other electronic media, including the following:

1. Medical exams and consultations
2. Behavioral health, including *substance abuse* evaluations and treatment.

The term does not include the delivery of health care services by use of the following:

1. A telephone transmitter for transtelephonic monitoring.
2. A telephone or any other means of communication for the consultation from one (1) provider to another provider.

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

Terminally ill means a *physician* has given a prognosis that a *member* has 12 months or less to live.

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

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

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

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

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

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

Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, *case management*, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage.

DEPENDENT MEMBER COVERAGE

Dependent Eligibility
Your dependent members become eligible for insurance on the latter of:

1. The date *you* became covered under this *contract;* or
2. The date of marriage to add a spouse; or
3. The date of a newborns birth; or
4. The date that an adopted child is placed with a *covered person* for the purposes of adoption or a *covered person* assumes total or partial financial support of the child.

Effective Date for Initial Dependents
The *effective date* for *your* initial *dependents,* if any, is shown on the *schedule of benefits*. Only *dependent members* included in the application for this *contract* will be covered on *your effective date*.

Coverage for a Newborn Child
An *eligible child* born to a *covered person* will be covered from the time of birth until the 31st day after its birth plus an additional 10 days for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. If notice of the newborn is given to *us* by the Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. If notice is given by the Marketplace within 60 days of the birth of the child, the *contract* may not deny coverage of the child due to failure to notify *us* of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless *we* have received notice by the Marketplace of the child's birth whether or not *you* have notified *us*.

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

The child will be covered on the same basis as any other dependent.

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and *we* have received notification from the Marketplace. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both: (A) Notification of the addition of the child from the Marketplace within 60 days of the birth or placement and (B) any additional premium required for the addition of the child within 90 days of the date of *placement.*

As used in this provision, *"placement"* means the date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption pursuant to an adoption proceeding.
Adding Other Dependents

If *you* are enrolled in an off-exchange *policy* and apply in writing to add a *dependent* and *you* pay the required premiums, *we* will send *you* written confirmation of the added *dependent member's effective date* of coverage and ID Cards for the added dependent.

ONGOING ELIGIBILITY

For All Members

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

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*;
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes;
3. The primary Member residing outside the Service Area or moving permanently outside the Service Area of this plan;
4. The date of a *member's* death;
5. 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*;
6. 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
7. 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 Marketplace, the date of termination that the Marketplace provides us upon *your* request of cancellation to the Marketplace.

For Dependent Members

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

Open Enrollment

There will be an open enrollment period for coverage on the Health Insurance Marketplace. The initial open enrollment period begins November 1, 2017 through December 15, 2017. *Qualified individuals* who enroll prior to December 15, 2017 will have an *effective date* of coverage on January 1, 2018.

Special Enrollment Period

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

1. A *Qualified individual* or *dependent* loses *minimum essential coverage*;
2. A *Qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption or placement for adoption;
3. A *Qualified individual*, who was not previously a citizen, national, or lawfully present individual gains such status;
4. A *Qualified* individual's enrollment or non-enrollment in a *qualified* health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities

as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

5. An enrollee adequately demonstrates to the Health Insurance Marketplace that the *Qualified* health plan in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the enrollee;
6. An individual is determined newly eligible or newly ineligible for *Advanced Premium Tax Credit* or has a chance in eligibility for *cost-sharing reductions*, regardless of whether such individual is already enrolled in a *Qualified* health plan;
7. A *Qualified individual* gains access to new Qualified health plans as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified health plan or change from one Qualified health plan to another one time per month; or
10. A Qualified individual or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide.

In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where a *qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

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

1. The *qualified individual* has not been determined eligible for *advanced payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *qualified individual* pays the entire premium for the first partial month of coverage as well as all *cost sharing*, thereby waiving the benefit of *advanced payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month.

PREMIUMS

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

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.

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.

Reinstatement
If *your contract* lapses due to nonpayment of premium, it may be reinstated provided:

1. *We* receive from *you* a written application for reinstatement within one year after the date coverage lapsed; and
2. The written application for reinstatement is accompanied by the required premium payment.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than 60 days before the date of reinstatement.

The Rescissions provision will apply to statements made on the reinstatement application, based on the date of reinstatement.

In all other respects, *you* and *we* will have the same rights as before *your contract* lapsed.

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

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

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

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

COST SHARING FEATURES

Cost sharing Features
We will pay benefits for *Covered Service*s 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
*Member*s may be required to pay *Copayments* at the time of services as shown in the *schedule of benefits*. Payment of a *Copayment* does not exclude the possibility of an additional billing if the service is determined to be a non-*covered service*. *Copayments* do not apply toward the *Deductible* amount, but do apply toward meeting the Maximum Out-of-Pocket amount.

Coinsurance Percentage
Members may be required to pay a *Coinsurance* Percentage in excess of any applicable *Deductible* amount(s) for a *Covered Service* or supply. *Coinsurance* amounts do not apply toward the *Deductible* but do apply toward meeting the Maximum Out-of-Pocket Amount. When the annual *out-of-pocket* maximum has been met, additional *covered service expenses* will be 100%.

Deductible
The *deductible amount* means the amount of *covered service expenses* that must be paid by all *members* before any benefits are payable. If on a family plan, if one *member* of the family meets his or her *deductible*, benefits for that *member* will be paid. The *deductible amoun*t does not include any *copayment amount* or *coinsurance* amount. Not all *covered service expenses* are subject to the *deductible* amount. See *your schedule of benefits* for more details.

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 out-of-pocket maximum.

ACCESS TO CARE

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

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

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

Network Availability
Your network is subject to change. The most current *network* may be found online at our website or by contacting *us* at the number shown on *your* identification card. A *network* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *contract* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

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

MEDICAL EXPENSE BENEFITS

Ambulance Service Benefits

Covered service expenses will include ambulance services for local transportation:

1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.
3. Transportation between hospitals or between a hospital and skilled nursing or *rehabilitation* facility when *authorized* by Ambetter from Home State Health.

Benefits for air ambulance services are limited to:

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

Exclusions:

No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-*emergency* air ambulance.
3. 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 Expense Benefit

Covered service expenses for *autism spectrum disorder* include *coverage* for the diagnosis of *autism spectrum disorders* and for the *treatment of autism spectrum disorders*.

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

Clinical Trial Coverage

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

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

Clinical trials must meet the following requirements:

1. Phase I and II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and the insured is enrolled in the clinical trial. This section shall not apply to insured who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.
2. One of the National Institutes of Health (NIH);
3. The Centers for Disease Control and Prevention;
4. The Agency for Health Care Research and Quality;
5. The Centers for Medicare & Medicaid Services;
6. A cooperative group or center of any of the entities listed above or the Department of Defense or the Department of Veteran Affairs;
7. An NIH Cooperative Group or Center;
8. The FDA in the form of an investigational new drug application;
9. The federal Departments of Veterans' Affairs, Defense, or Energy;
10. An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects;
11. The study or investigation is a drug trial that is exempt from having such an investigational new drug application; or
12. A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

In a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. A qualified individual must be eligible to participate in the clinical trial, and either (a) have a referral from a doctor stating that the clinical trial would be appropriate based upon the individual having cancer or a life-threatening disease or condition; or (b) the individual must provide medical and scientific information establishing that their participation in the clinical trial would be appropriate based on the individual having cancer or a life-threatening disease or condition.

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

The coverage required by this section is subject to the standard *contract* provisions applicable to other benefits, including *deductible* and *coinsurance*.

Diabetic Care
Benefits are available for *medically necessary* services and supplies used in the treatment of diabetes.

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

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

1. The equipment, supply or appliance is a covered service;
2. The continued use of the item is *medically necessary*; and
3. There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

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

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

Benefits for repairs and replacement do not include the following:

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

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

<u>Durable medical equipment</u>
The rental (or, at *our* option, the purchase) of durable medical equipment prescribed by a *physician* or other provider. *Durable medical equipment* is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are *covered services*.

Payment for related supplies is a *covered service* only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the *member*; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered services may include, but are not limited to:

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

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

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

<u>Medical and surgical supplies</u>
Coverage for non-durable medical supplies and equipment for management of disease and treatment of medical and surgical conditions.

Covered services may include, but are not limited to:

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

Exclusions:
Non Covered Services include but are not limited to:

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

Prosthetics

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

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

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

Covered Services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for prosthetic devices, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the *member* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (the first one following cancer treatment, not to exceed one per benefit period).

Exclusions:

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

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

Orthotic devices

Covered services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding,

fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

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

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

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

Exclusions:
Non-covered services include but are not limited to:

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

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits
Covered service expenses include expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision;
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay;
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, filled by a licensed pharmacist, and approved by the U.S. Food and Drug Administration;
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
5. Coverage for a Skilled Nursing Facility and inpatient rehabilitation is limited to 150 days per year.
6. *Habilitation* Services are limited to 20 visits per year for Occupational Therapy and Physical Therapy. There is not a visit limit for Speech Therapy.
7. *Rehabilitation* Services are limited to 20 visits per year for Occupational Therapy and Physical Therapy. There is not a visit limit for Speech Therapy.
8. Coverage for Cardiac *Rehabilitation*.

See the *schedule of benefits* for benefit levels or additional limits.

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

1. The *member* has reached *maximum therapeutic benefit*;
2. Further treatment cannot restore bodily function beyond the level the *member* already possesses;
3. There is no measurable progress toward documented goals; and
4. Care is primarily *custodial care*.

Definition:
As used in this provision, *"provider facility"* means a *hospital, rehabilitation facility*, or *extended care facility*.

Home Health Care Service Expense Benefits
Covered service expenses for *home health care* are limited to the following charges:

1. *Home health aide services*;
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care;*
3. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your Schedule of Benefits for any limits associated with this benefit.
4. I.V. medication and pain medication;
5. Hemodialysis, and for the processing and administration of blood or blood components;
6. *Medically necessary medical supplies*;
7. Rental of *medically necessary durable medical equipment;* and
8. Sleep studies.

I.V. medication and pain medication are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient* hospital stay.

At *our* option, *we* may *authorize* the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we authorize* before the purchase. If the equipment is purchased, the *member* must return the equipment to *us* when it is no longer in use.

Limitations:
See the *schedule of benefits* for benefit levels or additional limits for expenses related to home health aide services.

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care under the Home Healthcare Expense Benefits.

Hospice Care Service Expense Benefits
This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice care program*. *Covered services* include:

The list of *covered service expenses* in the Miscellaneous Medical Service Expense Benefits provision is expanded to include:

1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. The rental of medical equipment while the *terminally ill member* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *member* had been confined in a *hospital.*

3. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
4. Counseling the *member* regarding his or her *terminal illness.*
5. *Terminal illness counseling* of the *member's immediate family.*
6. *Bereavement counseling*.

Benefits for *hospice inpatient,* home or *outpatient* care are available to a *terminally ill member* for one continuous period up to 180 days per benefit period. For each day the *member* is confined in a *hospice,* benefits for room and board will not exceed the most common semiprivate room rate of the *hospital* or nursing home with which the *hospice* is associated.

Exclusions and Limitations:
Any exclusion or limitation contained in the *contract* regarding:

1. An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;
2. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program;* or
3. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Respite Care Expense Benefits
Respite care is covered on an *inpatient or outpatient basis to allow* temporary relief to family members from the duties of caring for a *member* who is undergoing *hospice* care. Respite days that are applied toward the *deductible amount* are considered benefits provided and shall apply against any Maximum Benefit limit for these services. See *your schedule of benefits* for limits.

Hospital Benefits
Covered service expenses are limited to charges made by a *hospital* for:

1. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
2. A private hospital room when needed for isolation.
3. Daily room and board and nursing services while confined in an *intensive care unit*.
4. *Inpatient* use of an operating, treatment, or recovery room.
5. *Outpatient* use of an operating, treatment, or recovery room for *surgery.*
6. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* for use only while *you* are *inpatient.*
7. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See *your schedule of benefits* for limitations.

Infertility Services
Covered services for infertility treatment are limited to diagnostic testing to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy and semen analysis. Benefits are included to treat the underlying medical conditions that cause infertility (such as endometriosis, obstructed fallopian tubes and hormone deficiency).

Mammography Coverage
Typical breast cancer screening mammography, which includes the following:

1. If the *member* is at least thirty-five (35) years of age but less than forty (40) years of age, coverage for at least one (1) baseline breast cancer screening mammography performed upon *member* before they become forty (40) years of age; or

2. If the *member* is less than forty (40) years of age and at risk, one (1) typical breast cancer screening mammography performed upon the *member* every year; or
3. If the enrollee is at least forty (40) years of age, one (1) typical breast cancer screening mammography performed upon the *member* every year; and
4. Any additional mammography views that are required for proper evaluation; and
5. Ultrasound services, if determined *medically necessary* by the *physician* treating the *member*.

Mental Health and Substance Use Disorder Benefits

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 *Member*s 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 use 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 abuse* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

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

Inpatient

1. *Inpatient* Psychiatric Hospitalization;
2. *Inpatient* detoxification treatment;
3. Observation;
4. Crisis Stabilization;
5. *Inpatient Rehabilitation*;
6. Residential Treatment facility for mental health and substance abuse; and
7. Electroconvulsive Therapy (ECT).

Outpatient

1. Traditional *outpatient* services, including individual and group therapy services;
2. Medication management services;
3. Partial Hospitalization Program (PHP)
4. Intensive *Outpatient* Program (IOP);
5. Day treatment;
6. *Outpatient* services for the purpose of monitoring drug therapy;
7. *Outpatient* detoxification programs;

8. Psychological and Neuropsychological testing and assessment;
9. *Outpatient rehabilitation* treatment;
10. Applied Behavioral Analysis;
11. Mental Health day treatment
12. *Autism Spectrum Disorders;*
13. Telemedicine*;*
14. Psychological Testing; and
15. Electroconvulsive Therapy (ECT).

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

Medical Foods
We cover medical foods and formulas when medically necessary for the treatment of Phenylketonuria (PKU).

Chiropractic Services
We cover charges for chiropractic services. These services will be covered for a *member* who presents a condition of an orthopedic or neurological nature necessitating treatment for which falls within the scope of a licensed chiropractor.

Medical and Surgical Expense Benefits
Medical *covered service expenses* are limited to charges:

1. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
2. For services received for urgent care, including facility charges at an urgent care center.
3. Made by a *physician* for professional services, including *surgery.*
4. Made by an assistant surgeon.
5. For dressings, crutches, orthopedic splints, braces, casts, or other *medically necessary medical supplies.*
6. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
7. For chemotherapy and radiation therapy or treatment.
8. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
9. For the cost and administration of an anesthetic.
10. For oxygen and its administration.
11. For *dental service expenses* when a *member* suffers an *injury,* that results in:
    a. Damage to his or her natural teeth;
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within 12 months of the accident to be considered as a covered service; and
    c. *Injury* to the natural teeth will not include any injury as a result of chewing.
12. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint. See the *schedule of benefits* for benefit levels or additional limits.
13. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.

14. For Chiropractic Care, including office visits for assessment, evaluation, spinal adjustment, *medically necessary manipulative therapy* treatment on an *outpatient* basis and physiological therapy before (or in conjunction with) spinal adjustment up to 26 visits per benefit period; visits in excess of 26 will require *prior authorization*
15. For pulse oximetry screening on a newborn.
16. Well Child care examinations for children through the age of 12, including child health supervision services, based on American Academy of Pediatric Guidelines. Refer to Preventive Services for a list of well child/well baby services.
17. For medically necessary human organ and tissue transplants.
18. Family Planning for certain professional Provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.
19. For treatment received outside the United States *while* traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
20. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.
21. Allergy testing, injections and serum.
22. For the provision of nonprescription enteral formulas and food products required for *members* with inherited diseases of amino acids and organic acids. Such coverage shall be provided when the prescribing *physician* has issued a written order stating that the enteral formula or food product is medically necessary and is the least restrictive and most cost effective means for meeting the needs of the *member*. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein;
23. For scalp hair prosthesis expenses for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia, or permanent loss of scalp hair due to injury. Such coverage, shall be subject to a written recommendation by the treating *physician* stating that the hair prosthesis is a medical necessity;
24. For children's early intervention therapy for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers working with children from birth to 36 months of age with an identified developmental disability and/or delay as long as the providing therapist receives a referral from the child's *primary care provider* if applicable;
25. For medically necessary diagnostic and laboratory and x-ray tests;
26. Cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. Coverage is limited to a maximum cost of $75.
27. Dental anesthesia charges include coverage for the administration of general anesthesia and hospital charges for dental care, rendered by a dentist, provided to the following *members*:
    a. a child under the age of five;
    b. a person who is severely disabled; or
    c. a person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.
28. For the treatment of breast cancer by dose-intensive chemotherapy/*autologous bone marrow transplants* or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/*autologous bone marrow transplants* or stem cell transplants.
29. For cancer screenings, as follows:
    a. A pelvic examination and pap smear for any nonsymptomatic woman who is a *member*, in accordance with the current American Cancer Society guidelines;

b. A prostate examination and laboratory tests for cancer for any nonsymptomatic man who is a *member*, in accordance with the current American Cancer Society guidelines; and
c. A colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic *member*, in accordance with the current American Cancer Society guidelines.

30. For telemedicine for *covered service*s provided within the scope of practice of a physician or other healthcare provider as a method of delivery of medical care by which a member shall receive medical services from a healthcare provider without in-person contact with the provider;
31. For Medically Necessary oral surgery, including the following:
    a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
    b. Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw bone and is Medically Necessary to attain functional capacity of the affected part.
    c. Oral / surgical correction of accidental injuries as indicated in the "Dental Services" section.
    d. Surgical services as described in the "Temporomandibular Joint (TMJ) and Craniomandibular Joint Services" section.
    e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
    f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
    g. Surgical procedures that are Medically Necessary to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
    h. Reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, *illness*, *injury* or an earlier treatment in order to create a more normal appearance. Benefits include *surgery* performed to restore symmetry after a mastectomy.
32. For respiratory and pulmonary therapy;
33. For *medically necessary* genetic blood tests; and
34. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).

Outpatient Medical Supplies Expense Benefits

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

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the *member* and the item cannot be modified). If more than one prosthetic device can meet a *covered person's* functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered service expense*.
2. For one pair of foot orthotics per *member*.
3. For two mastectomy bras per year if the *member* has undergone a covered mastectomy.
4. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
5. For the cost of one Continuous Passive Motion (CPM) machine per *member* following a covered joint surgery.
6. For the cost of one wig per *member* necessitated by hair loss due to cancer treatments or traumatic burns. See the s*chedule of benefits* for benefit levels or additional limits.
7. Infusion therapy.
8. For one pair of eyeglasses or contact lenses per *member* following a covered cataract surgery. See the s*chedule of benefits* for benefit levels or additional limits.
9. Services related to diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a person licensed to practice medicine and surgery in the state, if the *member* has a condition or medical history for which bone mass measurement is medically indicated.
10. Testing of pregnant women and other *members* for lead poisoning.
11. For any other use of a drug approved by the United States Food and Drug Administration when the drug has not been approved by the United States Food and Drug Administration for the treatment of the particular indication for which the drug has been prescribed, provided such drug

is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies. Any coverage of a drug required shall also include medically necessary services associated with the administration of the drug. This benefit shall not be construed to require:

a. Coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
b. Coverage for experimental or investigational drugs not approved for any indication by the FDA; and
c. Reimbursement or coverage for any drug not included on the drug formulary or list of covered drugs specified in this *contract*.

Maternity Care

For maternity care of a *member* the length of *hospital* stay and the number of postpartum visits shall be determined by the attending healthcare provider based on clinical information that demonstrates that the *member* and infant are clinically stable based on nationally accepted guidelines and that appropriate care for the *member* and newborn can be provided for upon discharge. The length of stay shall not be determined by Home State Health or the *hospital* based on economic criteria. Any length of *hospital* stay shorter than the current minimum nationally accepted guidelines for perinatal care, such as Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, shall be at the recommendation of the attending healthcare provider in consultation with the *member*. In such cases Home State Health shall pay for at least 2 postpartum visits. During one such visit, the collection of an adequate sample from the newborn for screening for genetic and metabolic diseases shall take place.

Coverage for Maternity Care includes: *outpatient* and *inpatient* pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, physician services for delivery of a baby, including circumcision, and hospital stays for delivery, complications of pregnancy or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*).

Maternity coverage of a home birth by a midwife or nurse midwife is limited to low risk Pregnancy and may be subject to *preauthorization* requirements.

Newborns' and Mothers' Health Protection Act Statement of Rights

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

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, *we* may provide benefits for *covered service expenses* incurred for a shorter stay if the attending provider (e.g., *your physician*, nurse midwife or *physician* assistant), after consultation with the mother, discharges the mother or newborn earlier.

The level of benefits and out-of-pocket costs for any later part of the 48-hour or 96-hour stay will not be less favorable to the mother or newborn than any earlier part of the stay. *We* do not require that a *physician* or other healthcare provider obtain *authorization* for prescribing a length of stay of up to 48 hours or 96 hours.

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

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

1. A *prescription drug;*
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a physician;
3. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) standard reference compendium; or
    b. Recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain; and
4. Prescribed, oral anticancer medication;
5. Self-administered human growth hormones to treat persons with short stature who have an absolute deficiency in natural growth hormone. Benefits are also available to treat persons with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant.

See the *schedule of benefits* for benefit levels or additional limits.

Covered prescription drugs, which are not subject to utilization management, *prior authorization*, or pre-certification requirements, and are considered maintenance, are covered up-to-90-day supply at retail pharmacies within our network. Controlled substances as identified by the United States Drug Enforcement Administration are exempt from this section. The prescription drugs received in a 90-day supply may be subject to co-payments, *coinsurance deductible*s, or other member cost shares.

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *physician.* If *we* change our formulary we will provide *you* with notification of the change at least thirty (30) days in advance of the change.

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

Non-Covered Services and Exclusions:
No benefits will be paid under this benefit subsection for services provided or expenses incurred:

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance;
2. For immunization agents otherwise not required by the Affordable Care Act
3. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals;
4. For a refill dispensed more than 12 months from the date of a *physician's* order.
5. Due to a *member's* addiction to, or dependency on foods.
6. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
7. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary, or when the over-the-counter drug is used for preventive care.
8. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
9. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program;

10. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
11. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription.
12. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
13. Off-label use, except as required by law or as expressly approved by us;
14. Foreign Prescription Medications, except those associated with an Emergency Medical Condition while you are traveling outside the United States, or those you purchase while residing outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States;
15. Drugs or dosage amounts determined by Ambetter 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; or
16. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.

Pediatric Vision Expense Benefits

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

1. Routine vision screening, including dilation and with refraction every *calendar year*;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of contacts every *calendar year*, including standard polycarbonate lenses, scratch resistant and anti- reflective coating;
3. One pair of frames every *calendar year*.
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when *pre-authorized.*
5. UV coating.
6. Photochromic lenses.
7. Non-Elective Contact Lenses – Only for the following medical conditions:
    a) Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
    b) High Ametropia exceeding -12D or +9D in spherical equivalent.
    c) Anisometropia of 3D or more.
    d) When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Covered service expenses do not include:

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

Preventive Care Expense Benefits

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. Examples of these services are screenings for cervical cancer and mammography.

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
4. Additional preventive care and screenings not included above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.
5. All FDA-approved contraception methods (identified on www.fda.gov) are approved for *member*s without *cost sharing* as required under the Affordable Care Act. *Member*s have access to the methods available and outlined on our Drug Formulary or Preferred Drug List without cost share. Some contraception methods are available through a *member*'s medical benefit, including the insertion and removal of the contraceptive device at no cost share to the *member*; and
6. Covers without *cost sharing*:
    a. Screening for *tobacco use*; and
    b. For those who *use tobacco* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior *authorization*; and
        ii. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a healthcare provider without prior *authorization*.

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

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

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

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

You may access *our* website or the Member Services Department at 1-855-650-3789 to get the answers to many of *your* frequently asked questions regarding preventive services. *Our* website has resources and features that make it easy to get quality care. *Our* website can be accessed at http://ambetter.homestatehealth.com/.

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

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

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.

Transplant Expense Benefits

If *we* determine that a *member* is an appropriate candidate for a *listed transplant,* benefits will be provided for:

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

Transplant Donor Expenses:

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

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

Ancillary "*Center Of Excellence*" Service Benefits:

A *member* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence, covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.

Non-Covered Services and Exclusions:

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

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
2. For animal to human transplants.
3. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.

4. To keep a donor alive for the transplant operation.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants not included under this provision as a listed transplant.

Food and Drug Administration (FDA) regulation, regardless of whether the trial is subject to FDA oversight. For a listed transplant under study in an ongoing phase I or II clinical trial as set forth in the United States

Wellness and Other Program Benefits

Benefits may be available to Members from time to time for participating in certain programs that we may make available in connection with this *Contract*. Such programs may include wellness programs, disease or *case management* programs, and other programs such as smoking cessation. The benefits available to Members for participating in such programs are described on the *schedule of benefits*. *You* may obtain information regarding the particular programs available at any given time by visiting our website at ambetter.homestatehealth.com or by contacting Member Services at 1-855-650-3789. The programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change from time to time by us through an update to program information available on our website or by contacting us.

PRIOR AUTHORIZATION

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

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

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

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

Except for *medical emergencies*, prior *authorization* must 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
Network providers cannot bill *you* for services for which they fail to obtain *prior authorization* as required. Benefits will not be reduced for failure to comply with *prior authorization* requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

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

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

1. The predetermination was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.

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

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

Utilization Review
Utilization Review is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, *case management*, discharge planning or retrospective review. Utilization review does not include elective requests for clarification of coverage;

Authorization means that treatment is considered to be medically appropriate and medically necessary by *our* team of *physician* advisors based on the medical information provided by the treating *physician*. For an initial determination, a determination will be made within two working days of obtaining all necessary information regarding a proposed admission, procedure or service. In the case of a determination to certify an admission, procedure or service, the provider rendering the service will be notified by telephone within twenty-four hours of making the initial *authorization*, and written or electronic confirmation of the telephone notification will be provided to the *member* and the provider within two working days of making the initial *authorization*.

A Notice of *Prior Authorization* includes:

1. The number of certified days of hospital confinement;
2. The medical diagnosis, and if applicable, the surgical procedure that was certified;
3. Instructions for a physician to request additional days of hospital confinement (if necessary); and
4. Instructions regarding questions about the *authorization* process.

Non-Authorization

If treatment is not *medically appropriate* and *medically necessary*, the *provider* will be informed of non-*authorization* by telephone within twenty-four hours of making the adverse determination, and written or electronic confirmation of the telephone notification will be provided to the *member* and the *provider* within one working day of making the adverse determination. If a *member* decides to receive non-certified medical treatment, then no benefits are paid. The *member* may elect to file an appeal with *us*. At all times, the final decision for actual medical treatment to be provided is the right and responsibility of the *member* and the *physician.*

Concurrent Review Determinations

For concurrent review determinations, a determination will be made within one working day of obtaining all necessary information. In the case of a determination to certify an extended stay or additional services, the *provider* rendering the service will be notified by telephone within one working day of making the *authorization*, and written or electronic confirmation of the telephone notification will be provided to the *member* and the *provider* within one working day after the telephone notification. The notification will include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an adverse determination, the *provider* rendering the service will be notified by telephone within twenty-four hours of making the *authorization*, and written or electronic confirmation of the telephone notification will be provided to the *member* and the *provider* within one working day after the telephone notification. In any case, services will be continued without liability to the *member* until the *member* has been notified of a determination.

Retrospective Review Determinations

For retrospective review determinations, a determination will be made within thirty working days of receiving all necessary information. A written notice of the determination will be provided to the *member* within ten working days of making the determination.

Reconsideration of Determination

In a case involving an initial determination or a concurrent review determination, the *provider* rendering the service may request on behalf of the *member* a reconsideration of an adverse determination by the reviewer making the adverse determination. The reconsideration will occur within one working day of the receipt of the request and will be conducted between the *provider* rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination is not available within one working day. If the reconsideration process does not resolve the difference of opinion, the adverse determination may be appealed by the *member* or the *provider* on behalf of the *member*. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an adverse determination.

Notification

It is *your* responsibility to notify *us* and arrange for the release of necessary medical information from *your physician* to the Utilization Review Organization. *You* may also arrange for the *hospital* or *your physician* to notify the Utilization Review Organization; however, if for any reason *your physician* or

hospital fails to cooperate, the penalty applies as described in the Failure to Obtain *Prior Authorization* provision of this section.

Notification is required for all *hospital confinements*, *psychiatric care*, *outpatient surgeries*, *major diagnostic tests*, *home health care*, *extended care facility* confinements, *hospice services, rehabilitation facility* confinements, *skilled nursing facilities* and *transplants*. Notification MUST take place at least two weeks prior to the scheduled confinement, treatment or service.

Services from Non- Network Providers
Except for *emergency* medical services, unless *Covered Service*s are not available from Network Providers within a reasonable proximity such services will not be covered. If required *medically necessary* services are not available from Network Providers *you* or the Network Provider must request *Prior Authorization* from us before *you* may receive services from Non-Network Providers. Otherwise *you* will be responsible for all charges incurred.

HOSPITAL BASED PROVIDERS
When receiving care at an Ambetter participating *hospital* it is possible that some *hospital*-based providers (for example, anesthesiologists, radiologists, pathologists) may not be under contract with Ambetter as participating 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 status 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 *MEMBER*S 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.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *member* in the absence of insurance covering the charge.
2. Expenses/surcharges imposed on the *member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a member of a *member's immediate family.*
4. Any services not identified and included as *covered service expenses* under the *contract*. *You* will be fully responsible for payment for any services that are not *covered service expenses.*

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract,* except as expressly provided for under the Benefits after Coverage Terminates clause in this *policy's* Termination section.
2. For any portion of the charges that are in excess of the *eligible service expense.*
3. For weight modification, bariatric surgery, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery* and weight loss programs, except as specifically covered in this *contract*.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well- being of the *member,* such as sex-change *surgery*.
6. For the reversal of sterilization and the reversal of vasectomies.
7. For abortion (unless *medically necessary* or the life of the mother would be endangered if the fetus were carried to term).
8. For artificial insemination (AI), assisted reproductive technology(ART) procedures or the diagnostic tests and drugs to support AI or ART procedures.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
11. For telephone consultations or for failure to keep a scheduled appointment.
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.
13. For stand-by availability of a *medical practitioner* when no treatment is rendered.
14. For *dental service expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Service Benefits.
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect.
16. For diagnosis or treatment of nicotine addiction, except as otherwise covered under the Preventive Care Expense Benefits provision of this *policy*.
17. For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.

18. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits.
19. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
20. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
21. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
22. For vocational or recreational therapy, vocational *rehabilitation*, *outpatient* speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
23. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
24. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
25. For hearing aids, except as expressly provided in this *contract*.
26. For the treatment of infertility except as expressly provided in this *contract.*
27. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
28. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of 180 consecutive days. If travel extends beyond 180 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 180 days.
29. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
30. As a result of:
    a. An *injury* or *illness* caused by any act of declared or undeclared war.
    b. The *member* taking part in a riot.
    c. The *member's* commission of or attempt to commit a felony, whether or not charged, or to which a contributing cause was the insured's being engaged in an illegal occupation.
31. For any *illness* or *injury* incurred as a result of the *member* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician,* except as expressly provided for under the Mental Health and Substance Abuse Expense Benefits provision of this *contract*.
32. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
33. For or related to surrogate parenting.
34. For or related to treatment of hyperhidrosis (excessive sweating).
35. For fetal reduction surgery.
36. Except as specifically identified as a *covered service expense* under the *contract*, services or

expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

37. As a result of any *injury* sustained while at a *residential treatment facility.*
38. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date.
39. For the following miscellaneous items: artificial insemination (except where required by federal or state law); blood and blood products; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*.
40. For court ordered testing or care unless *medically necessary*.
41. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
42. Care provided or billed by residential treatment centers or facilities.
43. Services or care provided or billed by a school, *Custodial Care* center for the developmentally disabled.
44. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
45. Services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not you assert your rights to obtain this coverage or payment of these services.
46. Biofeedback.

TERMINATION

Termination of Contract

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date 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.
3. The date we decline to renew this *contract*, as stated in the Discontinuance provision.
4. The date of your death, if you are the only member on this *contract*.
5. The date that you accept any direct or indirect contribution or reimbursement through wage adjustment or otherwise, by or on behalf of an employer for any portion of the premium for coverage under this *contract*, or the date your employer and you treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date your eligibility for insurance under this *contract* ceases due to losing network access as the result of a permanent move.
7. The date your eligibility for insurance under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
8. The date your eligibility for coverage under this *Contract* ceases as determined by the Exchange.

If this *contract* is other than an individual coverage only plan (i.e. includes family coverage), it may be continued after *your* death:

1. By *your spouse*, if a *member;* otherwise,
2. By the youngest child who is a *member.*

This *contract* will be changed to a plan appropriate, as determined by *us,* to the *member(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the primary *member*. A proper adjustment will be made in the premium required for this *contract* to be continued. *We* will also refund any premium paid and not earned due to *your* death. The refund will be based on the number of full months that remain to the next premium due date.

Refund upon Cancellation

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

Discontinuance

90-Day Notice: If *we* discontinue offering and refuse to renew all *contracts* issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, *we* will provide a written notice to *you* at least 90 days prior to the date that *we* discontinue coverage. *You* will be offered an option to purchase any other coverage in the individual market *we* offer in *your* state at the time of discontinuance of this *contract*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice: If *we* discontinue offering and refuse to renew all individual *contracts* in the individual market in the state where *you* reside, *we* will provide a written notice to *you* and the Director of the

Missouri Department of Insurance at least 180 days prior to the date that *we* stop offering and terminate all existing individual *contracts* in the individual market in the state where *you* reside.

Portability of Coverage
If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *contract* by issuing an individual *policy*. The premium rate applicable to the new *policy* will be determined based on the *residence* of the person continuing coverage. All other terms and conditions of the new *policy*, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new *contract* to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family *deductible* which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new *contract* will be applied toward the satisfaction of the *deductible amount* under the new *contract*.)

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

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

Notification Requirements
It is the responsibility of *you* or *your* former *dependent member* to notify *us* within 31 days of *your* legal divorce or *your dependent member's* marriage. *You* must notify *us* of the address at which their continuation of coverage should be issued.

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

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

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

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

REIMBURSEMENT

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

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

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

1. To fully cooperate with *us* in order to obtain information about the *loss* and its cause.
2. To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by *us* on behalf of a *member* in any claim made against any *third party*.
4. That *we*:
    a. Will have a lien on all money received by a *member* in connection with the *loss* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert that subrogation right independently of the *member*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
9. That *we* may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse *us*.

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

We have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise. If a dispute arises as to the amount a *member* must reimburse *us*, the *member* or the guardian, legal representatives, estate, or heirs of the *member* agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by *us* until the dispute is resolved

We will not pay attorney fees or costs associated with the *member's* claim or lawsuit unless *we*

previously agreed in writing to do so.

COORDINATION OF BENEFITS

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

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

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

A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and nongroup insurance contracts; Health insuring corporation (HIC) contracts; Coverage under group or nongroup closed panel plans (whether insured or uninsured); Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan as permitted by law.
2. Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; Accident only coverage; Specified disease or specified accident coverage; Supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; School accident-type coverage; Non-medical components of long term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1 and 2 above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan. This Plan means, in a COB provision the part of the Contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when *you* have health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

Allowable Expense is a health care expense, including *deductible*s, *coinsurance* and *copayments*, that is covered at least in part by any Plan covering *you*. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering *you* is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging *you* is not an Allowable Expense. The following are examples of expenses that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room.
2. If *you* are covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If *you* are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If *you* are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans . However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the Primary plan because *you* have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed Panel Plan is a Plan that provides health care benefits to *you* primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of *emergency* or referral by a panel member.

Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the *calendar year* excluding any temporary visitation.

Order of Benefit Determination Rules

When *you* are covered by two or more plans, the rules for determining the order of benefit payments are as follows. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the *contract* holder. Examples include major medical coverage that are superimposed over base hospital and surgical benefits, and insurance type coverage that are written in connection with a Closed Panel Plan to provide out-of-network benefits. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan. Each Plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent. The plan that covers *you* other than as a dependent, (for example as an employee, member, policyholder, subscriber or retiree) is the Primary Plan and the Plan that covers *you* as a dependent is the Secondary Plan. However, if *you* are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering *you* as a dependent, and primary to the Plan

covering *you* as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering *you* as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other plan is the Primary Plan.

Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a child is covered by more than one Plan the order of benefits is determined as follows:

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

Active Employee or Retired or Laid-off Employee

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

COBRA or State Continuation Coverage

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

ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

Longer or Shorter Length of Coverage
The Plan that covered *you* as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered *you* the shorter period of time is the Secondary Plan. If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

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

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

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

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

Coordination Disputes
If *you* believe that we have not paid a claim properly, *you* should first attempt to resolve the problem by contacting us at 1-855-650-3789 or http://ambetter.homestatehealth.com/. *You* should also refer to the Complaint and Appeals procedures. If *you* are still not satisfied, *you* may call the Missouri Department of Insurance for instructions on filing a consumer *complaint*. Call 1-800-686-1526, or visit the Department's

website at *http://insurance.Missouri.gov* .

CLAIMS

Notice of Claim
We must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible. Notice given by or on behalf of *you* at 16090 Swingley Ridge Road, Suite 500, Chesterfield, MO 63017, or to any authorized agent of *ours*, with information sufficient to identify *you*, will be deemed notice to *us*.

Claim Forms
Upon receipt of a notice of claim, *we* will furnish to *you* or *your dependent* such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice *you* or *your dependent* will be deemed to have complied with the requirements of this *policy* as to proof of loss upon submitting, within the time fixed in the *policy* for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss
Written proof of loss must be furnished to *us* in case of claim for loss for which this *policy* provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Cooperation Provision
Each *member*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *contract* and, as often as may be reasonably necessary:

1. Sign, date and deliver to *us authorization*s to obtain any medical or other information, records or documents *we* deem relevant from any person or entity;
2. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant;
3. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask; and
4. Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*.

If any *member*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *contract*.

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

Time for Payment of Claims
Benefits will be paid immediately upon receipt of *proof of loss*. Should we determine that additional supporting documentation is required to establish responsibility of payment, we shall pay benefits upon

receipt of such additional supporting documentation.

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

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

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

If a proper claim is submitted by a public hospital or clinic, benefits payable will be paid to such hospital or clinic with or without an assignment from *you* or *your dependent*. Payment of benefits to the public hospital or clinic pursuant to this paragraph shall discharge us from all liability to *you* or *your dependent* to the extent of benefits paid.

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

Assignment
We will reimburse a *hospital* or health care provider if:
1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

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

Custodial Parent
This provision applies if the parents of a covered *eligible child* are divorced or legally separated and both the custodial parent and the non-custodial parent are subject to the same court or administrative order establishing custody. The custodial parent, who is not a *member*, will have the rights stated below if *we* receive a copy of the order establishing custody.

Upon request by the custodial parent, *we* will:
1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the *contract*;
2. Accept claim forms and requests for claim payment from the custodial parent; and
3. Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge *our* obligations.

A custodial parent may, with *our* approval, assign claim payments to the *hospital* or *medical practitioner* providing treatment to an *eligible child*.

Physical Examination
We have the right and opportunity to examine a *member* while a claim is pending or while a dispute over the claim is pending. These examinations are made at *our* expense and as often as *we* may reasonably require. *We*, at our own expense, have the right and opportunity to make an autopsy of *member* in case of death where it is not forbidden by law.

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

GRIEVANCE PROCESS

We want to fully resolve *your* problems or concerns. *We* will not hold it against *you*, or treat *you* differently, if *you* file a Grievance. A Grievance is a formal *complaint* about actions taken by *us* or a *network* provider. Grievances are any oral or written expression of dissatisfaction submitted to *us* that has been initiated by *you*, or *your* authorized representative, concerning any aspect of our product or action taken by *us*, relative to *you*, including but not limited to, review of Adverse Determinations regarding scope of coverage, denial of services, quality of care, and administrative operations. A Grievance involving the review of an Adverse Determination (disagreement with a Medical Necessity determination) is an Appeal and the steps for an Internal Appeal are also detailed in this document.

How to File a Grievance
Filing a Grievance will not affect *your* healthcare services. We want to know *your* concerns so we can improve our services.

To file a Grievance, call Member Services at 855-650-3789 (TDD/TTY) 1-877-250-6113. *You* can also write a letter and mail or fax your Grievance to *us* at 1-855-805-9812. Be sure to include:

1. *Your* first and last name;
2. *Your* member ID number;
3. *Your* address and telephone number;
4. Why *you* are unhappy (with as much specific information as possible);
5. Any supporting documentation; and
6. What *you* would like to have happen (desired outcome).

You have up to 180 calendar days to file a Grievance. The 180 calendar days start on the date of the situation *you* are not satisfied with. We would like for *you* to contact us right away so we can help *you* with *your* concern as soon as we can. A Grievance may be filed in writing by mail at the address below, or by fax at 1-855-805-9812. *You* can also call *us* at 855-650-3789 (TDD/TTY) 1-877-250-6113 or file the Grievance in person at:

Grievances and Appeals Coordinator
Ambetter from Home State Health
16090 Swingley Ridge Road
Suite 500
Chesterfield, MO 63017

First Level Grievance Review
If *you* submit *your* Grievance by phone or in person, a Member Services Representative will write a summary of *your* Grievance and send *you* a copy within 10 days (unless the time limit is waived or extended by mutual written agreement between *you*, or *your* authorized representative, and *us*. This summary serves as both a written record of *your* Grievance as well as an acknowledgement. If *you* file a written Grievance, the Appeals and Grievance Coordinator will send *you* a letter within 10 business days letting *you* know that we have received *your* Grievance and the expected date of resolution.

If someone else is going to file a Grievance for *you*, we must have *your* written permission for that person to file a Grievance or Appeal on *your* behalf. *You* will need to obtain and fill out an Authorized Representative Form, and return it to us so we will know who *you* have granted permission to represent *you*. The Authorized Representative Form can be obtained by calling Member Services at 1-855-650-3789 (TDD/TTY) 1-877-250-6113 or by visiting our website at http://ambetter.homestatehealth.com.

If *you* have any proof or information that supports *your* Grievance, *you* may send it to us and we will add it to *your* case. *You* may supply this information to *us* by email, fax, in person, or other written method. *You* may also request to receive copies of any documentation that *we* used to make the decision about *your* care, Grievance, or Appeal.

We may need to obtain additional information to review *your* request. If a signed Authorization to Release Information is not included with *your* Grievance, a form will be sent to *you* for *your* signature. If a signed authorization is not provided within 30 business days of the request, *we* may issue a decision on the Grievance without review of some or all of the information. When a signed request is received by *your* authorized representative, appropriate proof of the designation must be provided.

You can expect a resolution and a written response within 20 calendar days of *your* Grievance. If the grievance is considered urgent, we will respond within 72 hours. If *we* need more than 20 calendar days to resolve the Grievance, we will contact *you* to receive written approval for additional time. The length of the extension will be mutually agreed upon, and will not last longer than 14 calendar days from the date of the agreement.

Within 5 business days after the resolution someone not involved in the circumstances giving rise to the grievance or its investigation will decide upon the appropriate resolution of the grievance and notify the *you* in writing of *our* decision regarding the grievance and of *your* right to file an appeal for a second-level review.

There will be no retaliation against *you* or *your* representative for filing a Grievance or Appeal.

Second Level Grievance Review
Upon receipt of a request for second level review, Home State Health will submit the *grievance* to a grievance advisory panel consisting of:

- Other Home State Health insureds;
- Representatives of Home State Health that were not involved in the circumstances giving rise to the *grievance* or in any subsequent investigation or determination of the *grievance*; and
- Where the *grievance* involves an adverse determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance.

Review by the grievance advisory panel will follow the same time frames as a first level review, except as provided in the provision "Expedited Review," if applicable. Any decision of the grievance advisory panel will include notice of the insured person's rights to file an appeal with the director's office of the grievance advisory panel's decision. The notice must include the following information:

Director, Missouri Department of Insurance
P.O. Box 690, Jefferson City, Missouri 65102
1-800 726-7390

Expedited review
An expedited review may be requested by a *member*, his representative or a *provider* acting on behalf of a *member* when a non-expedited review would reasonably appear to seriously jeopardize the life or health of the *member* or jeopardize the *member's* ability to regain maximum function. A request for an expedited review may be submitted orally or in writing.

Upon receipt of request for an expedited review of a determination, we will notify the *member* orally within seventy-two hours and written confirmation of our decision within three working days of providing notification of the determination.

At any time, the eligible grievant/*claimant* may file a grievance with the Director of the Missouri Department of Insurance at Missouri DIFP, Attn: Division of Consumer Affairs, P.O. Box 690, Jefferson City, Missouri, 65102, Telephone 1-800-726-7390.

INTERNAL APPEALS AND EXTERNAL REVIEW PROCEDURES

If *you* need help*: If you do not understand your rights or if you need assistance understanding your rights or you do not understand some or all of the information in the following provisions, you may contact us at the Member Services Department, 16090 Swingley Ridge Road, Suite 500, Chesterfield, MO 63017, by telephone at* 1-855-650-3789 *or by fax at* 1-855-805-9812.

Internal Claims and Appeals Procedures: When *we* deny a claim for a treatment or service (a claim for plan benefits, *you* have already received (post-service claim denial) or *we* deny *your* request to *authorize* treatment or service (pre-service denial), *you*, or someone *you* have authorized to speak on *your* behalf (an authorized representative), can request an appeal of *our* decision. If *we* rescind *your* coverage or deny *your* application for coverage, *you* may also appeal *our* decision. When *we* receive *your appeal*, *we* are required to review *our* own decision. When *we* make a decision, *we are* required to notify *you* (provide notice of a notices of *adverse benefit determination*) including:

1. The reasons for *our* decision;
2. *Your* right to file an appeal of the decision;
3. *Your* right to request an *external review*;
4. The availability of a Consumer Assistance Program at the Missouri Department of Insurance; and
5. If *you* do not speak English, *you* may be entitled to receive appeals' information in *your* native language upon request.

When *you* request an *internal appeal*, *we* must give *you our* decision as soon as possible, but no later than:

1. 72 hours after receiving *your* request when *you* are appealing the denial for urgent care. (If *your* appeal concerns urgent care, *you* may be able to have the internal appeal and external reviews take place at the same time.)
2. 30 days for appeals of denials of non-urgent care *you* have not yet received.
3. 60 days for appeals of denials of services *you* have already received (post-service denials).

No extensions of the maximum time limits will be permitted without your *consent*.

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

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

Defined terms: Any terms appearing in *italics*, and that have not been previously defined, are defined at the end of these provisions.

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

Your rights to file an appeal of denial of health benefits: *You* or *your* authorized representative, such as

your health care provider, may file the appeal for *you*, in writing, either by mail or by facsimile (fax). For an urgent request, *you* may also file an appeal by telephone:

Ambetter from Home State Health, Appeals Unit,
16090 Swingley Ridge Road, Suite 500
Chesterfield, MO 63017
Telephone at 1-855-650-3789 or by fax at 1-855-805-9812

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

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

Rescission of coverage: If *we* rescind (withdraw) *your* coverage, *you* may file an appeal according to the following procedures. *We* cannot terminate *your* benefits until all of the appeals have been exhausted. Since a rescission means that no coverage ever existed, if *our* decision to rescind is upheld, *you* will be responsible for payment of all claims for *your* health care services.

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

Time Limits for an External Appeal: *You* have 120 days to file for an *external review* after receipt of *our final adverse benefit determination*.

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

1. *We* must provide *you*, free of charge, with any new or additional evidence considered, relied upon, or generated by *us* (or at *our* direction) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal *adverse benefit determination* is required to give *you* a reasonable opportunity to respond prior to that date; and
2. The adverse determination must be written in a manner understood by *you*, or if applicable, *your* authorized representative and must include all of the following:
    a. The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);
    b. Information sufficient to identify the claim involved, including the date of service, the health care provider;
    c. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; and
    d. *Your* right to an independent external review.

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

Other Resources to help *you*

Department of Insurance: For questions about *your* rights or for assistance *you* may also contact the Missouri Department of Insurance.

Language services are available from *us* plan and from The Missouri Department of Insurance.

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

INTERNAL CLAIMS AND APPEALS

Non-urgent, pre-service claim denial

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

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

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

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

Urgent Pre-service (Expedited) Appeal If *your* claim for benefits is urgent, *you* or *your* authorized representative, or your health care provider (physician) may contact us with the claim, orally or in writing.

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

If *you* have not given us sufficient information, we will contact *you* as soon as possible after we receive *your* appeal to let *you* know the specific information we will need to make a decision.

To assure *you* receive notice of our decision, we will contact *you* by telephone or facsimile (fax) or by another method meant to provide the decision to *you* quickly. We will provide written notification to *you* within two business days of providing notification of the decision, if the initial notification is not in writing.

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

Simultaneous urgent claim and expedited internal review:

In the case of a claim involving urgent care, *you* or *your* authorized representative may also request an expedited internal review. A request for expedited internal review may be submitted orally or in writing by

the *claimant*; and all necessary information, including *our* benefit determination on review, will be transmitted between *us* and the *claimant* by telephone, facsimile, or other expeditious method.

Simultaneous urgent claim, expedited internal review and external review:

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

The *physician*, if the *physician* certifies, in writing, that *you* has a medical condition where the time frame for completion of an expedited review of an internal appeal involving an *adverse benefit determination* would seriously jeopardize *your* life or health or jeopardize *your* ability to regain maximum function, *you* may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal.

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

1. *You* have filed a request for an expedited internal review; and
2. After a final *adverse benefit determination*, either of the following applies:
    a. *Your* treating physician certifies that the *adverse benefit determination* involves a medical condition that could seriously jeopardize the life or health of *you*, or would jeopardize *your* ability to regain maximum function, if treated after the time frame of a standard external review; or
    b. The final *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care service for which *you* received *emergency* services, but have not yet been discharged from a facility.

Concurrent Care Decisions

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

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

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

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

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

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

Post-service appeal of a claim denial (retrospective)
If *your* appeal is for a *post-service claim denial*, we will notify *you* of our decision as soon as possible but no later than 60 days after we have received *your* appeal. If we need more time, we will contact *you*, telling *you* about the reasons why we need more time and the date when we expect to have a decision for *you*, which should be no later than 14 days, provided that the we determine that such an extension is necessary due to matters beyond our control, and we notify you prior to the expiration of the initial 30 days period.

If the reason we need more time to make a decision is because *we* do not have the necessary information, *you* will have 45 days from the date we notify *you* to provide us the information. We will describe the information needed to make our decision in the notice we send to *you*. This is also known as a "retrospective review." *We* will notify *you* of its determination as soon as possible but no later than 5 days after the benefit determination is made.

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

EXTERNAL REVIEW

Right to External Review
If *you*, or *your* authorized representative, are not satisfied with the final outcome of the Internal Appeal, Expedited Internal Appeal, or Expedited External Review, an External Review of the decision by the Missouri Department of Insurance may be requested.

You may file the request for an independent *external review* by contacting the Missouri Department of Insurance.

Members, or a *Member's* authorized representative, can request an External Review in the following situations:

1. The *member* receives a Final *Adverse Benefit Determination*; or
2. The benefit/service is a covered benefit/service and is not on the excluded list included in the *contract*

You or *your* authorized representative may request the External Review or the Expedited External Review. Forms and instructions for submitting the request will be included with the Final *Adverse Determination* letter we send. *Members* do not have to wait for the Final *Adverse Determination* letter in order to submit a request for an Expedited External Review; this can be submitted at the same time that the Member submits

a request for an Expedited Internal Appeal. . If the Missouri Department of Insurance determines the request qualifies for Expedited Review, a determination will be made within 4 days of the External Review agency receipt of the request.

For non-expedited External Reviews, the required forms must be completed then submitted to the Missouri Department of Insurance within 120 days of the receipt of the Final Adverse Determination we send. Non-expedited External Reviews will be completed, and a decision sent within 60 days of the external agency's receipt of the request unless accepted as an Expedited External Review.

An Expedited External Review may be requested if:

1. A provider certifies in writing a delay in receiving the requested service would result in a substantial risk of serious or immediate harm to *you;*
2. *You* are currently admitted as a patient in a hospital;
3. *You* are terminally ill; or
4. A provider certifies in writing a delay in receiving requested durable medical equipment would result in a substantial risk of serious or immediate harm to *you.*

Standard requests for an external review must be provided in writing; requests for expedited external reviews, including experimental/investigational, may be submitted orally or electronically. When an oral or electronic request for review is made, written confirmation of the request must be submitted to *us* no later than 5 days after the initial request was made.

If the External Review relates to the denial of ongoing services, *you* or *your* authorized representative may request from the Missouri Department of Insurance for services to continue during the External Review process. For non-expedited external reviews, such a request must be made before the end of the second business day following the receipt of the Final Adverse Determination letter sent. If the Missouri Department of Insurance decides coverage should continue because substantial harm could occur to *you* if coverage ended, *we* will continue coverage at our expense, minus applicable *copay*s and *deductible*s.

If *you* have questions, concerns, would like additional information regarding Member rights, or have questions about the External Review process *you* can contact the Missouri Department of Insurance:

Missouri Department of Insurance
Phone: 573-751-4126
PO Box 690, Jefferson City, MO 65102-0690

Non-urgent request for an external review

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

1. The name and contact information for the assigned independent review organization or the Missouri Department of Insurance, as applicable, for the purpose of submitting additional information; and

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

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

If *we* deny *your* request for an external review on the basis that the *adverse benefit determination* is not eligible for an external review, *we* will notify *you*, in writing, the reasons for the denial and that *you* have a right to appeal the decision to the Director of the Missouri Department of Insurance.

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

Request for external review to the Department of Insurance: If *we* deny *your* request for an *external review*, *you* may file a request for the Department of Insurance to review *our* decision by contacting the Missouri Department of Insurance at 573-751-4126.

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

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

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

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

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

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

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

If an *expedited external review* (urgent) was requested, the IRO will provide a determination as soon as

possible or within 72 hours of receipt of the expedited request. The IRO's decision is binding on *us*. If the IRO reverses *our* decision, *we* will immediately provide coverage for the health care service or services in question.

If the Missouri Department of Insurance or IRO requires additional information from *you* or *your* health care provider, the plan will tell *you* what is needed to make the request complete.

If *we* reverse *our* decision: If *we* decide to reverse *our* adverse determination before or during the external review, *we* will notify *you*, the IRO, and the Missouri Department of Insurance within one business day of the decision.

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

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

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

If the IRO an d Missouri Department of Insurance I uphold *our* decision, *you* may have a right to file a lawsuit in any court having jurisdiction.

Definitions

Adverse benefit determination means any of the following:

1. To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
    a. A determination that the health care service does not meet the *our* requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
    b. A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a nonemployer group, to participate in a plan or health insurance coverage;
    c. A determination that a health care service is not a covered benefit;
    d. The imposition of an exclusion, including an exclusion for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.
2. Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a nonemployer group;
3. To rescind coverage under this *contract*. a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of *your* or a *dependent*'s eligibility to participate in a plan under this *contract*..

Ambulatory review means utilization review of health care services performed or provided in an *outpatient* setting.

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

1. A person to whom a *member* has given express, written consent to represent that individual in an internal appeals process or external review process of an *adverse benefit determination*;

2. A person authorized by law to provide substituted consent for a *member*;
3. A family member but only when *you* are unable to provide consent.

Claim involving urgent care or *urgent care claims* mean any claim for medical care or treatment with respect to the application of the time periods for making non-urgent care determinations.

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

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

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

Emergency medical condition means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

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

Emergency services mean the following:

1. A medical screening examination, as required by federal law, that is within the capability of the *emergency* department of a hospital, including ancillary services routinely available to the *emergency* department, to evaluate an *emergency* medical condition;

2. Such further medical examination and treatment that are required by federal law to stabilize an *emergency* medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

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

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

Final adverse benefit determination means an *adverse benefit determination* that is upheld at the completion of *our* internal appeals process.

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

Health care provider or provider means a health care professional or facility.

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

Language assistance means translation services provided if requested. Contact customer service at 1-855-650-3789 if oral or written services are needed.

1. *We* must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;
2. *We* must provide, upon request, a notice in any applicable non-English language; and
3. *We* must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan or issuer.

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

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

Post-service claim means any claim for a benefit under this *contract* that is not a "pre-service claim."

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

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

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

GENERAL PROVISIONS

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

1. Change this *contract*;
2. Waive any of the provisions of this *contract*;
3. Extend the time for payment of premiums; or
4. Waive any of *our* rights or requirements.

Non-Waiver
If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *contract* that will not be considered a waiver of any rights under the *contract*. A past failure to strictly enforce the *contract* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions
No misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

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

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

Time Limit on Certain Defenses
After two years from the date of issue of this *policy* no misstatements, except fraudulent misstatements, made by *you* in the application for *your policy* may be used to void *your policy* or to deny a claim for loss incurred commencing after the expiration of such two-year period. In accordance with the foregoing, *we* have the right to terminate this *contract* if *you* commit fraud or make a material misrepresentation during the application process, or *we* determined it appropriate to comply with law.

No claim for loss incurred commencing after two years from the date of issue of this *contract* will 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 *contract*.

Conformity with State Laws
Any part of this *contract* in conflict with the laws of Missouri on this *contract's effective date* or on any premium due date is changed to conform to the minimum requirements of Missouri's laws.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Home State Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Home State Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-855-650-3789 (TTY/TDD 1-877-250-6113)。
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Home State Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Serbo-Croatian:	Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from Home State Health, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-855-650-3789 (TTY/TDD 1-877-250-6113).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Home State Health hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-650-3789 (TTY/TDD 1-877-250-6113) an.
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Home State Health، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Home State Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-650-3789 (TTY/TDD 1-877-250-6113)로 전화하십시오.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Home State Health вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-855-650-3789 (TTY/TDD 1-877-250-6113).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Home State Health, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Tagalog:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Home State Health के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-855-650-3789 (TTY/TDD 1-877-250-6113) पर कॉल करें।
Pennsylvania Dutch:	Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from Home State Health, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kawl 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Persian:	اگر شما، یا کسي که به او کمک مي کنيد سؤالي در مورد Ambetter from Home State Health داريد، از اين حق برخورداريد که کمک و اطلاعات را بصورت رايگان به زبان خود دريافت کنيد. براي صحبت کردن با مترجم با شماره 1-855-650-3789 (TTY/TDD 1-877-250-6113) تماس بگيريد.
Cushite:	Yoo sii ykn namaa gargaaraa jirtuu wa'ee Ambetter from Home State Health irra gaaffi qabaatan ta'ee gargaarsaa fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana wajiin dubadhuu,1-855-650-3789 irra bilbilli (TTY/TDD 1-877-250-6113).
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from Home State Health, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Amharic:	እርስዎ ወይም እርሰዎ የሚረዱት ሰው ስለ Ambetter from Home State Health ግብር ጥያቄ ካለዎት ያለምንም ወጪ በቋንቋዎ ድጋፍ እንዲሁም መረጃ የማግኘት መብት አለዎት፣ ፣ አስተርጓሚ ለማነጋገር በ 1-855-650-3789 (TTY/TDD 1-877-250-6113). ይደውሉ፣ ፣

Statement of Non-Discrimination

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

Ambetter from Home State Health:

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

If you need these services, contact Ambetter from Home State Health at 1-855-650-3789 (TTY/TDD 1-877-250-6113).

If you believe that Ambetter from Home State Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Grievance/Appeals Home State Health, 16090 Swingley Ridge Road, Suite 500, Chesterfield, MO 63017, 1-855-650-3789 (TTY/TDD 1-877-250-6113), Fax, 1-866-390-4429. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Home State Health is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Ambetter from Home State Health
Individual EPO Health Benefit Plan
Issued and Underwritten by Celtic Insurance Company

Home Office: 16090 Swingley Ridge Road, Suite 500, Chesterfield, MO 63017

AMENDMENT TO EVIDENCE OF COVERAGE

Please read the following amendment to the Ambetter from Home State Health Evidence of Coverage ("EOC") (99723MO0009) carefully. It contains changes to your health coverage effective on the later of January 1, 2018 or the effective date of the EOC to which it is attached.

THIS AMENDMENT is made part of the Ambetter from Home State Health EOC. Unless otherwise indicated herein, all terms herein shall have the same meaning attributed to such terms in the EOC, and references to applicable sections are to sections of the EOC. This Amendment, combined with your EOC and Schedule of Benefits, explain the details of your health care coverage.

Other than the changes noted no other changes have been made to the EOC. This Amendment does not waive or extend any part of the EOC other than as stated herein.

YOUR AMBETTER EOC IS AMENDED AS FOLLOWS:

The following provision is added to the PREMIUMS section, page 29, immediately following the Grace Period provision and prior to the Reinstatement provision:

Third Party Payment of Premiums

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 Service 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.